McKESSON
Empowering Healthcare

Physicians Practice Solutions

Medisoft 18
User Guide

September 2012

Produced in Cork, Ireland

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Preface

Where to Find Help

Online Help

Access the online Help screens to find detailed information on each feature in Medisoft. Online Help is available in two different ways:

- Context-Sensitive Help: For help in a particular part of Medisoft, click the area for which you need help and press F1. The help topic for that area will appear.
- Main Help File: To access the main help file, click the Help menu and select Medisoft Help. The main help file will appear, displaying the Contents tab. Use the Contents tab to view categorized topics for Medisoft. Use the Index and Search tabs to find out additional or specific information about Medisoft.

Training

There are various training options available. Please contact your local Value-Added Reseller or the Medisoft Sales Department at 800-333-4747 for information concerning these options.

Independent Value-Added Resellers

There are Value-Added Resellers in your area who are knowledgeable and efficient in selling, installing, troubleshooting, and supporting your Medisoft program. You can contact the Medisoft Sales Department at 800-333-4747 for the name of a qualified Value-Added Reseller in your area to give you hands-on help or search the Medisoft website at www.medisoft.com for a reseller in your area.

Technical Support

Call Support at (855) 675-8326 between the hours of 8:00 a.m. and 8:00 p.m Eastern Standard Time.

Medisoft Versions

Medisoft comes in three versions:

Product	Features
Basic	Offers basic features for processing patient visits, claims, payments, and reporting.
Advanced	Offers all that Basic does but provides greater reporting power, the ability to process secondary claims, as well as sending patient statements and collections processing.
Network Professional	Offers all the features of Basic and Advanced, but enables you to integrate with an Electronic Health Records (EHR) system.

Chapter 1 - Navigating in Medisoft

In this chapter, you will learn about the basics of navigating in Medisoft, using the menus and keyboard shortcuts.

Toolbars

There are four toolbars that you use to help you navigate in Medisoft.

Title Bar

The top bar on the screen is the Title bar and it displays the name of the active program and contains Minimize, Maximize, and Close buttons on the right side.

Figure 1. Title Bar

Menu Bar

Just below the Title bar is the Menu bar, which shows categories of activities available in Medisoft. Click one of the headings, such as File, Edit, Activities, Lists, Reports, Tools, screen, and Help, to open a submenu with a list of all the options available in that category. For more information on each drop-down menu, see "Menus" on page 3.

Figure 2. Menu Bar

Toolbar

Below the menu bar is the toolbar with an assortment of speed buttons (or icons) that are shortcuts to accessing options in Medisoft.

Figure 3. Toolbar

Select the option you want by clicking the appropriate button. To see the function of the toolbar button, hover the mouse cursor over it. The value will appear.

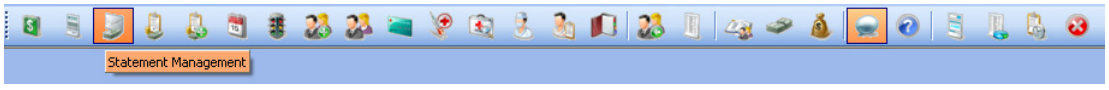

Figure 4. Medisoft toolbar with icon highlighted

Customizing the Toolbar

You can customize the toolbar to fit your needs. You can change the order of the buttons in the toolbar or remove them so they do not appear. You can create a new toolbar with only the buttons or file names that you want. In addition, you can move the toolbar to the top, bottom, or either side of the screen or return it to its original position and layout.

To customize the toolbar

1. Right-click an open space on the toolbar and select **Customize**. The Customize screen appears.

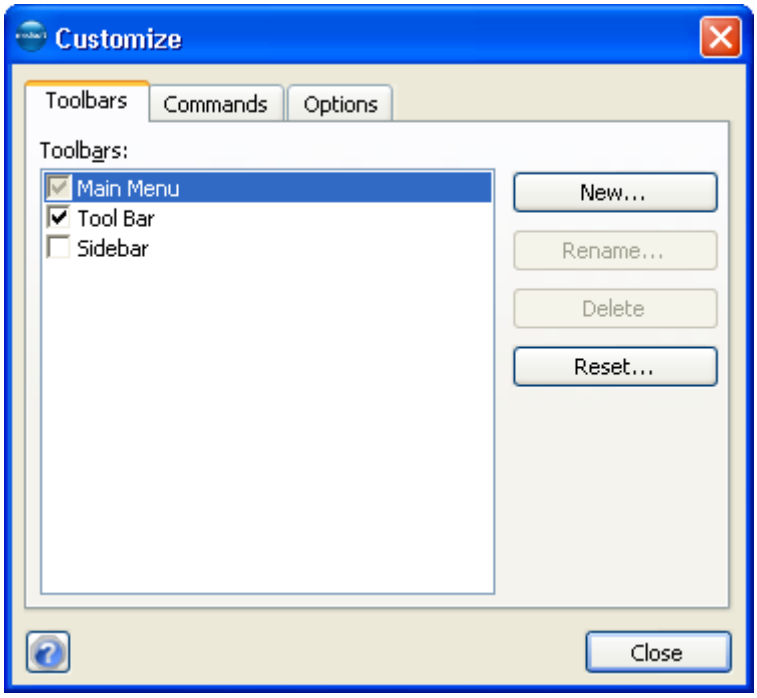

Figure 5. Customize screen

2. Use the options on the tabs to make your choices.
3. Click **Close** when you are done.

Shortcut Bar

Figure 6. Shortcut Bar

At the bottom of the screen, above the Status bar, is a shortcut bar that describes the available shortcut function keys available in the active screen. This bar may also be referred to as the "function help bar."

Menus

There are eight drop-down menus from the menubar that have options that allow you to work in Medisoft.

File Menu

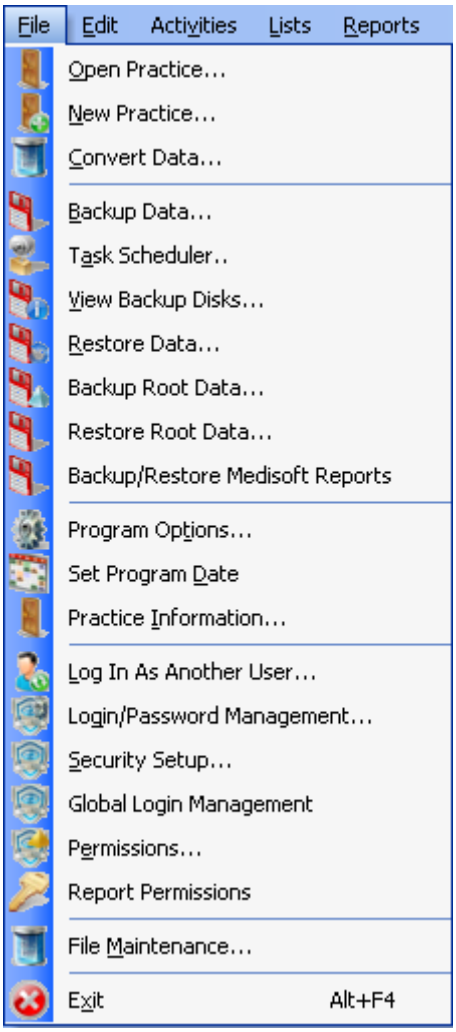

Figure 7. File menu

The File menu contains options for managing your practice files.

Edit Menu

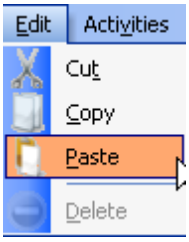

Figure 8. Edit menu

The functions of the Edit menu are Cut, Copy, Paste, and Delete.

Activities Menu

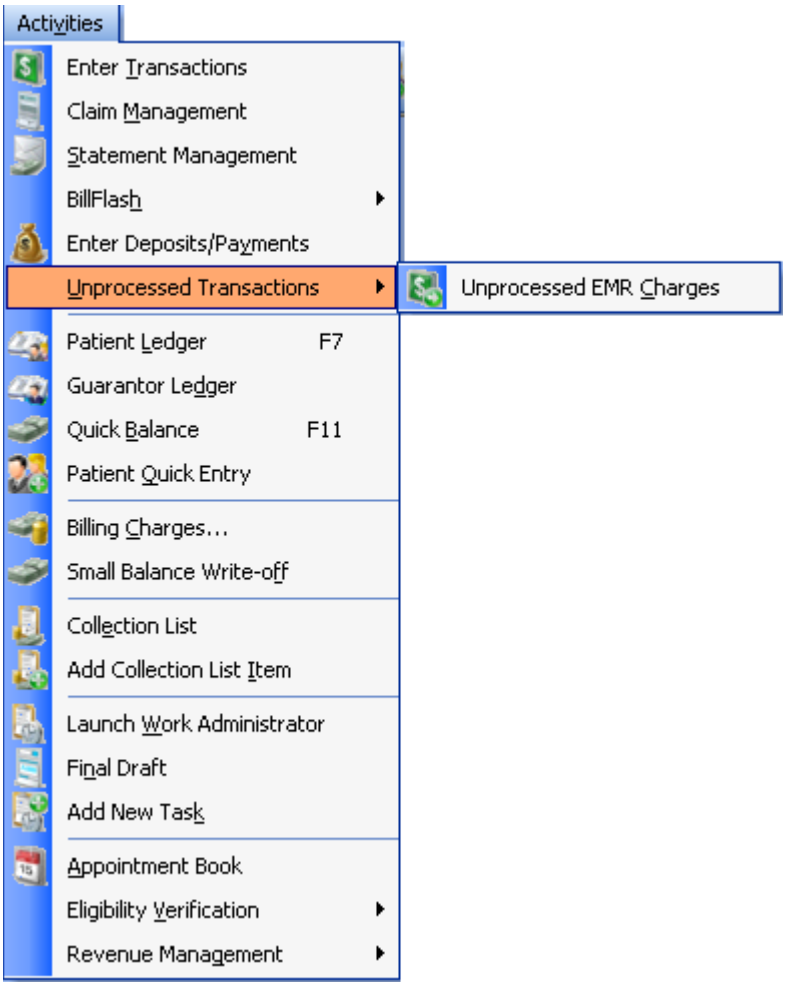

Figure 9. Activities menu

You will use the options on this menu for much of your daily routine. Here is where you enter transactions and payments, create claims, view balances, and open Office Hours.

Lists Menu

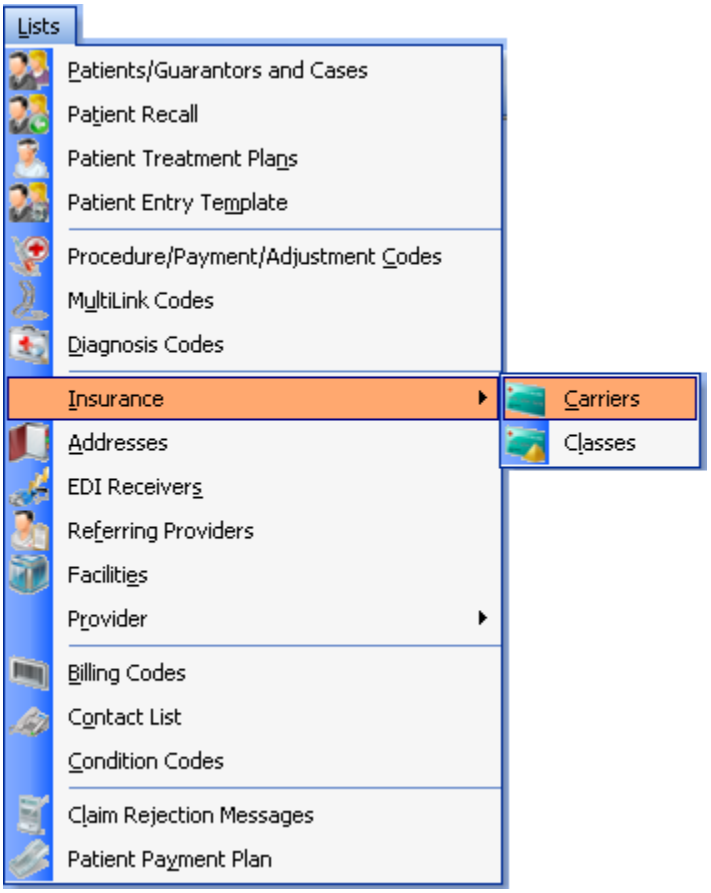

Figure 10. Lists menu

This menu provides access to the various list screens available in Medisoft. Here is where you will set up your patients, providers, insurance companies, diagnosis codes, and other basic data you will need to file claims and send statements to patients.

Reports Menu

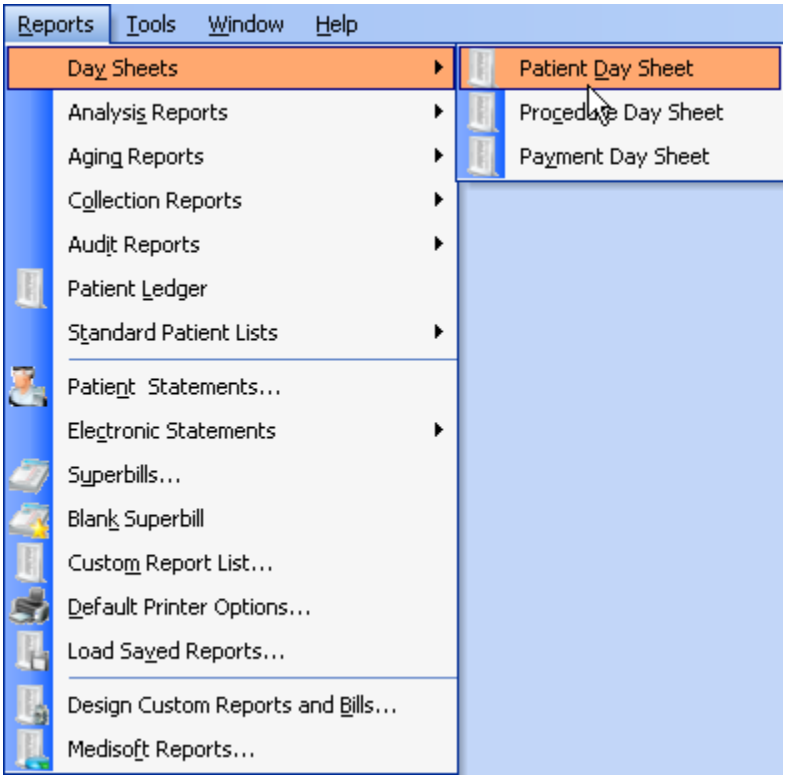

Figure 11. Reports menu

Reports within Medisoft are accessible through the Reports menu. A wide variety of reports enable to you to track your practice and see the state of your practice at any time.

Tools Menu

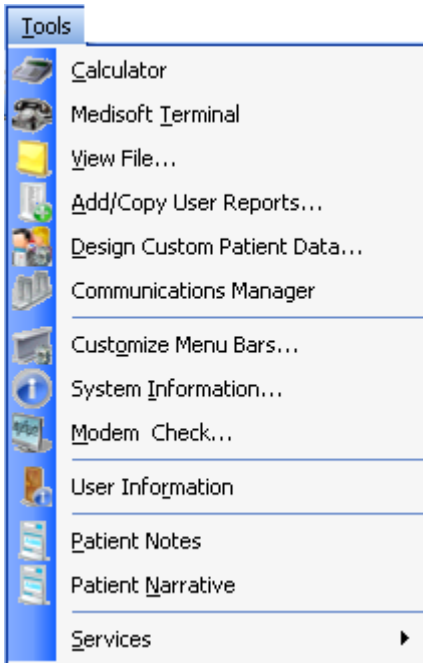

Figure 12. Tools menu

The options available in this menu help you access peripheral programs and information to help you manage your practice.

Window Menu

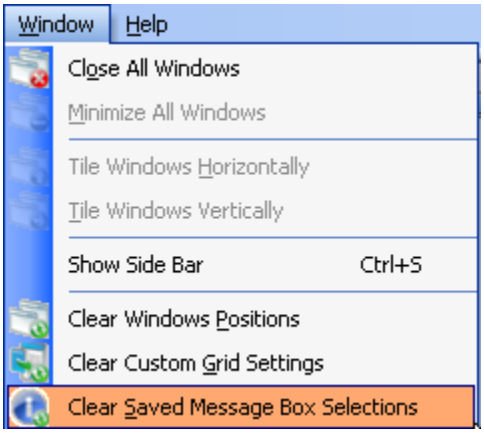

Figure 13. Window menu

This menu contains options that control the display of screens in Medisoft.

Help Menu

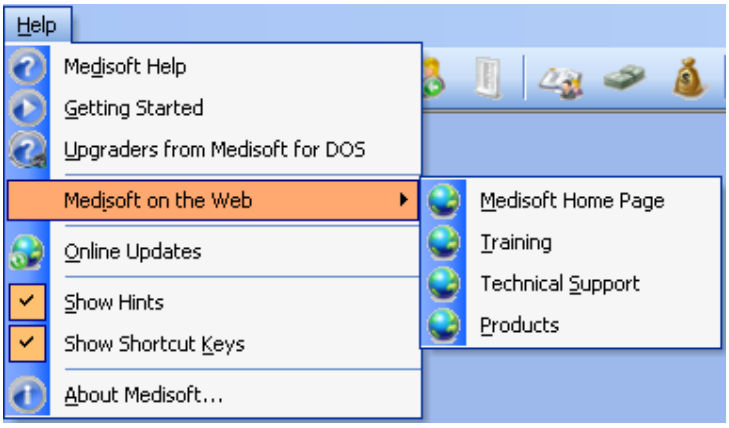

Figure 14. Help menu

The Help menu contains access to information on how to use Medisoft, as well as how to register.

Keystrokes and Shortcuts

Special keyboard shortcuts reduce the number of times you have to click the mouse or press keys to accomplish a task.

Common Keystrokes

Keystroke	Action
F1	Opens Help files in most screens.
ESC	Closes or cancels the current function or screen.
F3	Saves whatever you are working on.
F6	Opens a search screen
F7	Opens the Quick Ledger screen. For more information on this screen, see “Quick Ledger” on page 99.
F8	Opens a screen to create a new record.
F9	Opens a screen to edit the selected record.
F11	Opens the Quick Balance screen. For more information on this screen, see “Quick Balance ” on page 101.
SPACEBAR	Toggles a check box (check/uncheck).
ENTER	Depends on settings in the Program Options screen. For more information, see “Program Options” on page 169.
CTRL + S	Toggles the Sidebar display.
CTRL + X	Cuts the selected text.
CTRL + C	Copies the selected text.
CTRL + V	Pastes the text.
ALT + DOWN ARROW	Opens drop-down lists.

Keystrokes - List screens

Keystroke	Action
F2	Changes the value in the field.
F3	Saves the record.
F8	Creates a new record.
F9	Edits the selected record.

Keystrokes - Transaction Entry

Keystroke	Action
F2	Opens the MultiLink screen. For more information on this screen, see “MultiLink Codes” on page 73.
F4	Opens the Apply Payment to Charges screen. For more information on this screen, see “NOTE: Deposits/Payments is an Advanced and Medisoft Network Professional feature.” on page 123.
F5	Opens the Transaction Documentation screen.

Keystrokes - Eligibility

Keystroke	Action
F10	Opens the Eligibility Verification Results screen when Eligibility is enabled. For more information on this screen, see “Eligibility Verification” on page 137.

Chapter 2 - Medisoft at a Glance

This chapter provides a brief overview of the setup and use of Medisoft, in the general order in which you will want to set up your practice. For instance, you will first want to enter basic information on your practice, such as practice name and address. Then, you'll move on to entering information on the physicians in your practice (Providers), the insurance carriers your patients have, and then diagnosis and procedure codes.

For more detail on each area of the program, use the following table:

For more information about setting up...	see...
your practice	"Creating a Practice and Setup Overview" on page 21 and "Entering Practice Information" on page 41.
your providers	"Setting up Providers and Provider Classes" on page 47.
referring providers	"Referring Provider Records" on page 53.
insurance carriers	"Insurance Classes and Insurance Carriers" on page 57.
facilities	"Facility Information" on page 63.
addresses	"Attorney, Employer, or Other Addresses " on page 67.
procedure/payment/adjustment codes	"Procedure, Payment, and Adjustment Codes and Diagnosis Codes" on page 69.
diagnosis codes	"Diagnosis Codes" on page 75.
patients	"Patients" on page 81.

Setting up Your Practice Overview

You will first set up your practice. The Practice Information screen contains the basic information on your practice.

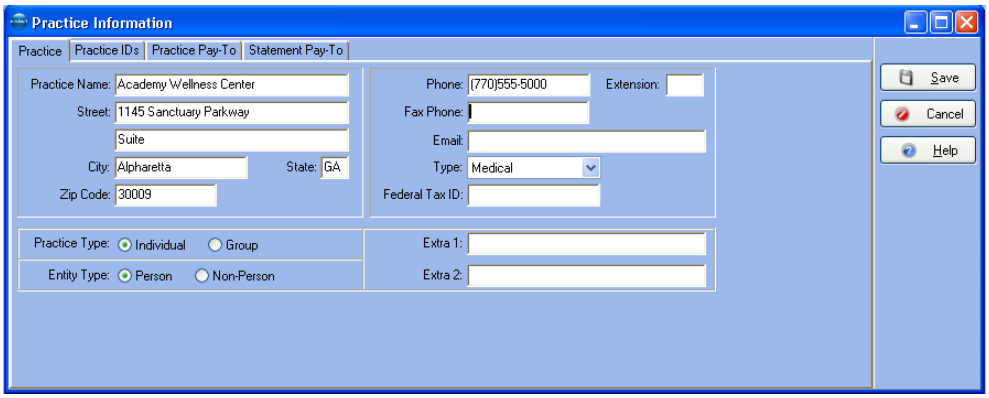

Figure 15. Practice Information screen

The Provider screen contains important information about the providers/physicians who are part of your practice.

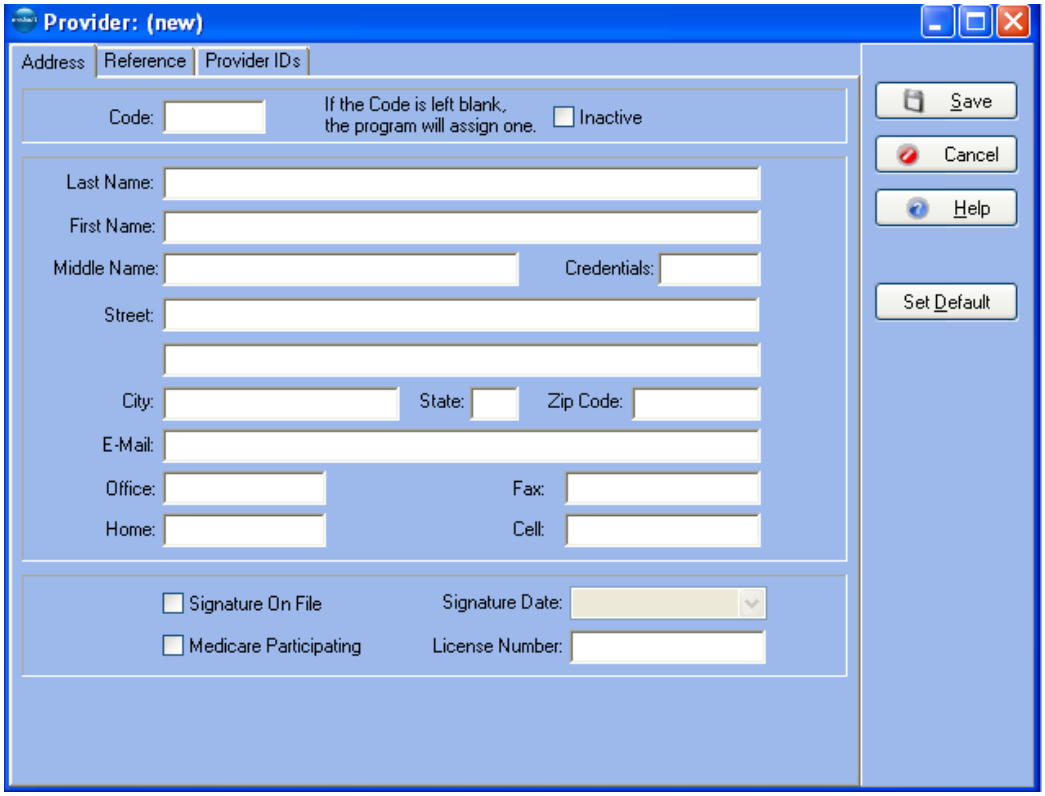

Figure 16. Provider screen

Each provider in the practice needs to have his or her own record set up in the database.

The Referring Provider screen contains information about the referring providers associated with your practice.

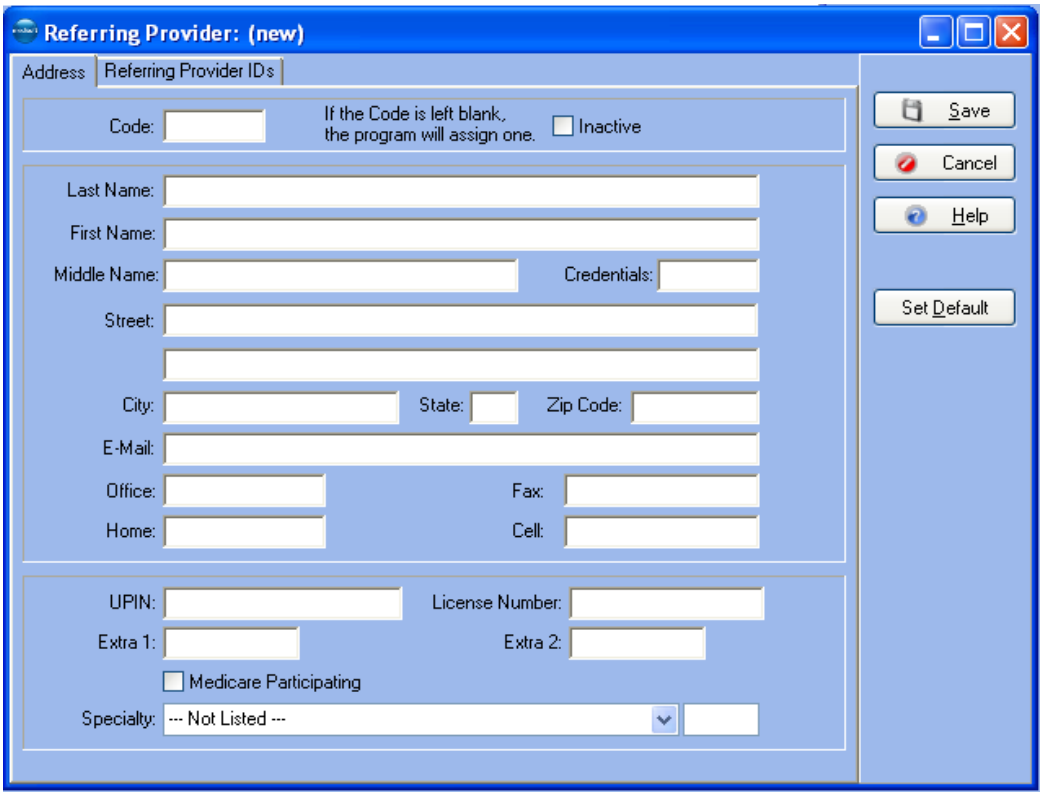

Figure 17. Referring Provider screen

You will use the Insurance Carrier screen to enter insurance carrier records. Keep a complete record of each ot your insurance carriers so that claims will be filed properly.

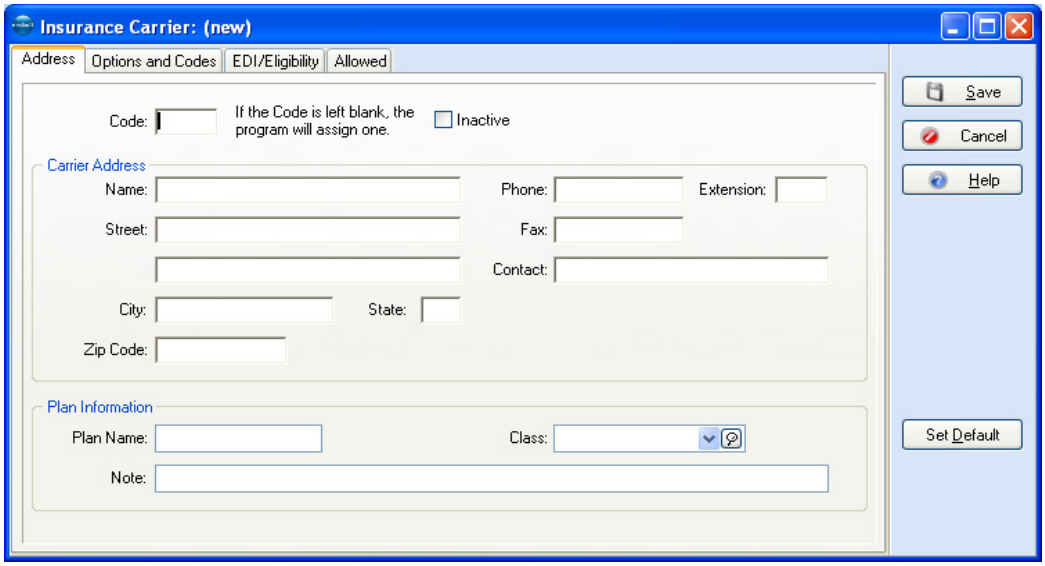

Figure 18. Insurance Carrier screen

The Facility screen contains information about the labs and facilities associated with your practice. Use the fields on this screen to enter information that is specific to the facility for claim filing purposes.

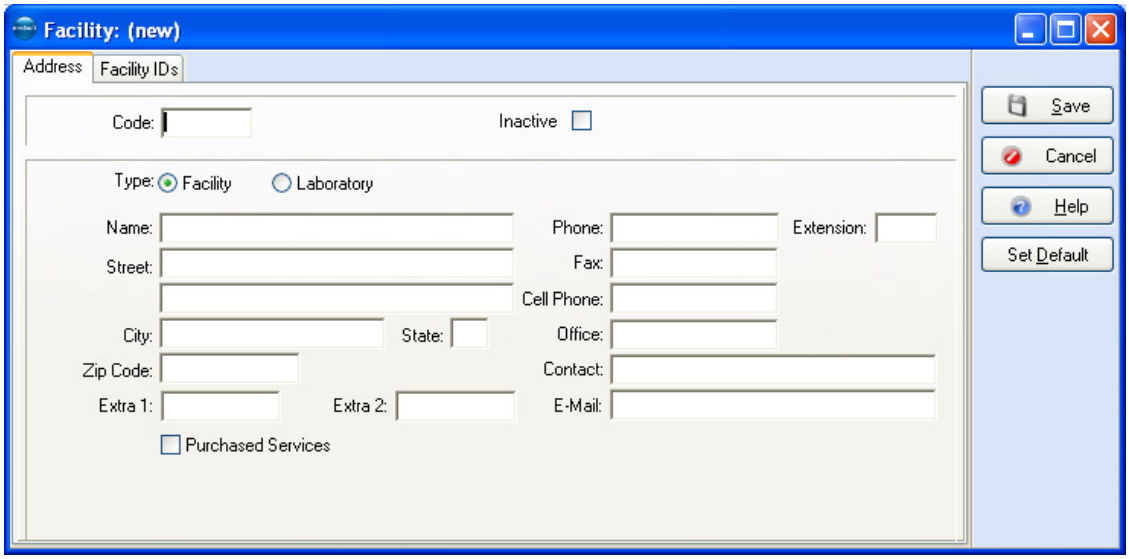

Figure 19. Facility screen

The Addresses screen is used to enter address information important to your practice, such as addresses of attorneys, employers, or referral sources.

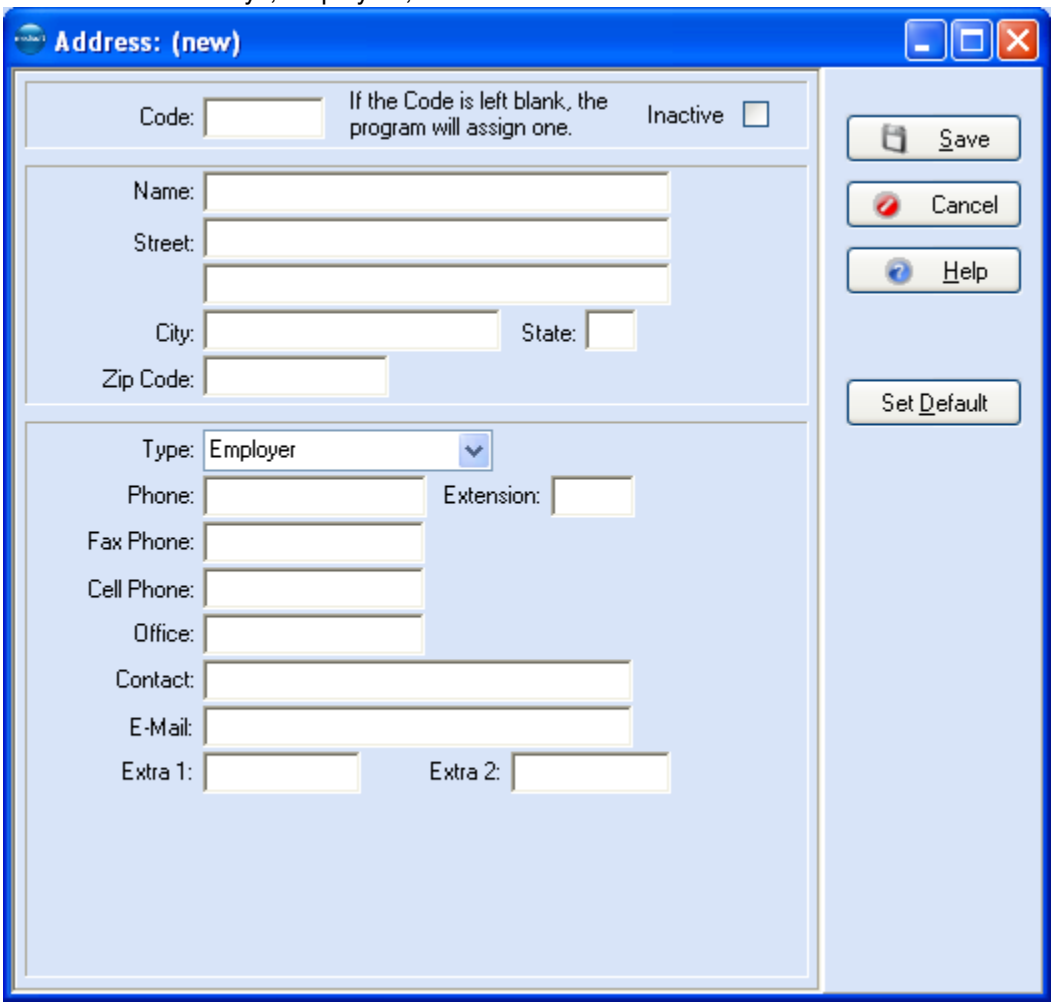

Figure 20. Address screen

The Diagnosis List screen displays diagnosis codes that have been set up for the practice. You can also identify codes that are HIPAA Approved. Use diagnosis codes in patient records, as well as during transaction entry. These will be part of each claim that is filed.

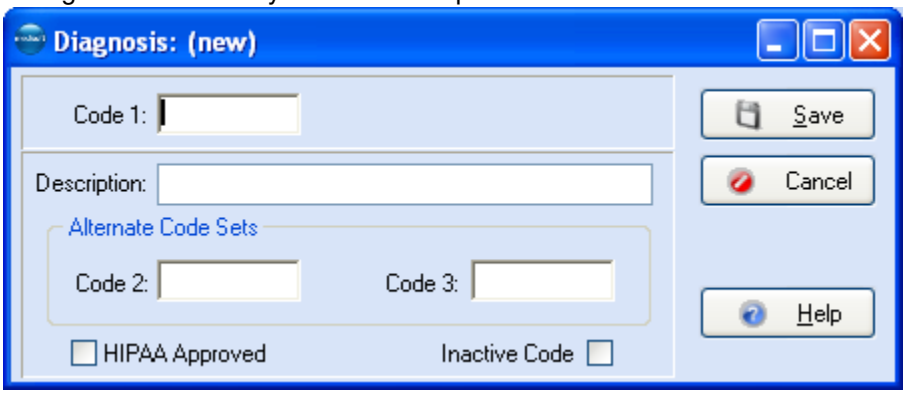

Figure 21. Diagnosis screen

You will use the Procedure/Payment/Adjustment Code screen to enter and edit procedure codes.

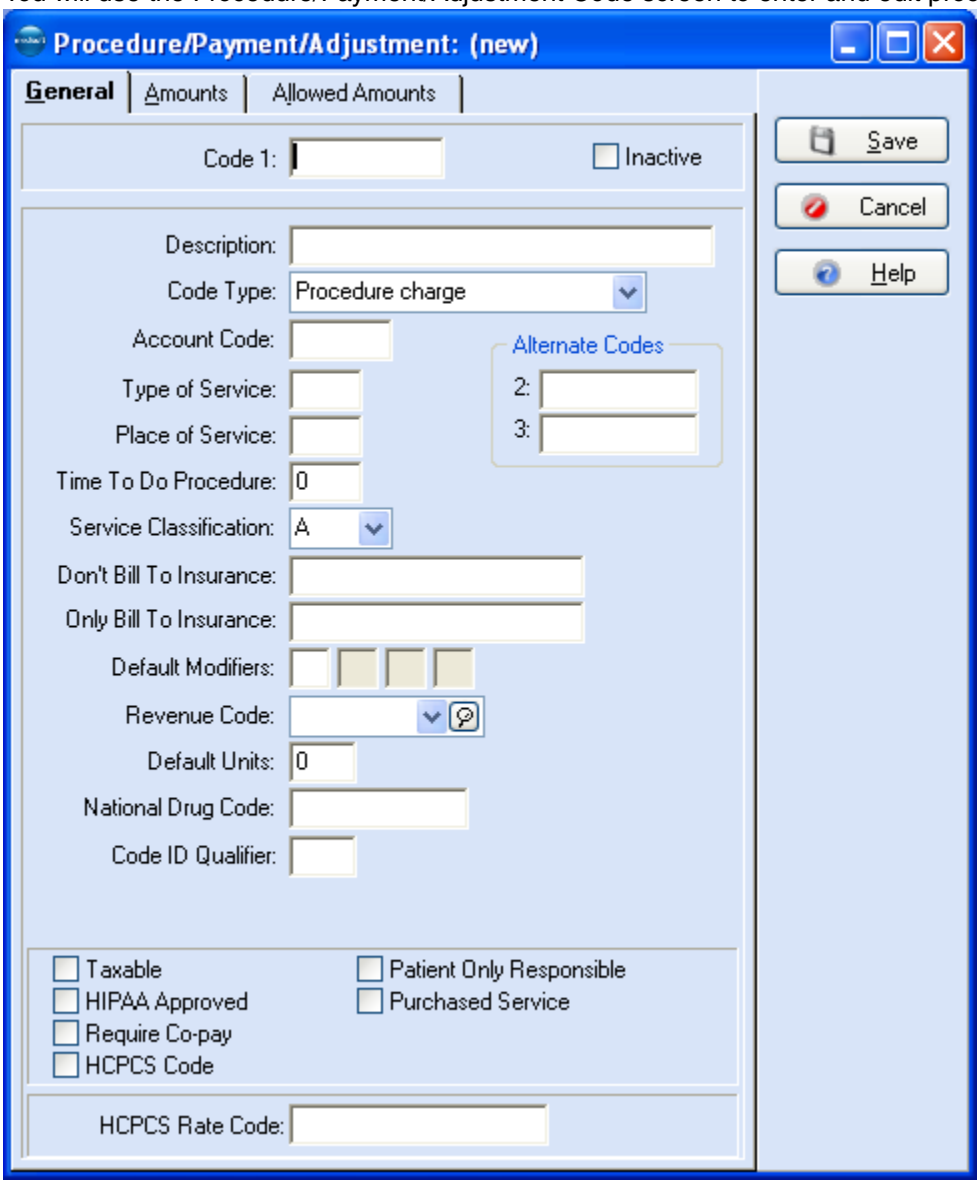

Figure 22. Procedure/Payment/Adjustment screen

The Patient screen is the main space for entering/editing patient and information.

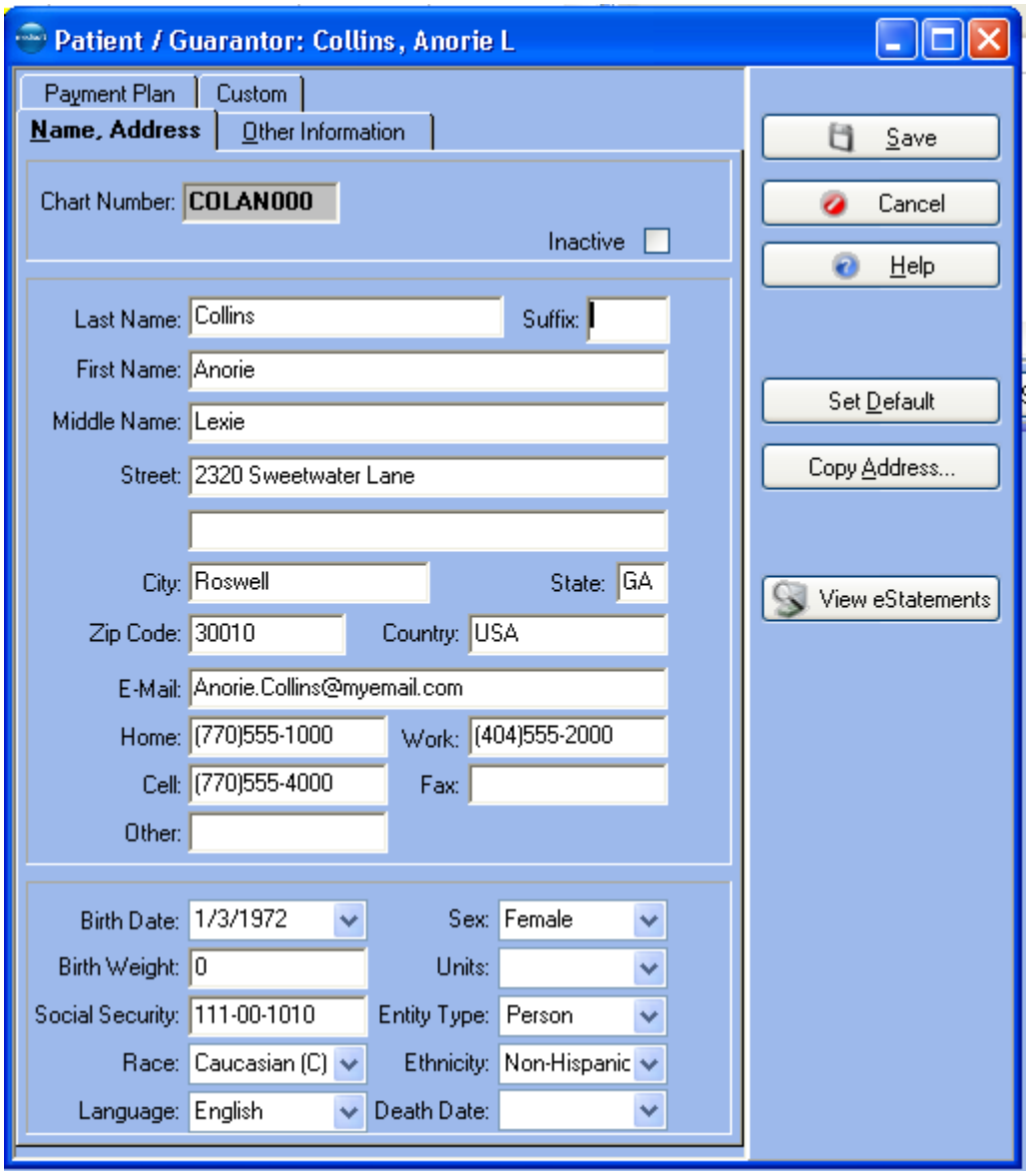

Figure 23. Patient/Guarantor screen

Entering Transactions and Payments

You enter charges via the Transaction Entry screen. You can also apply payments using this feature.

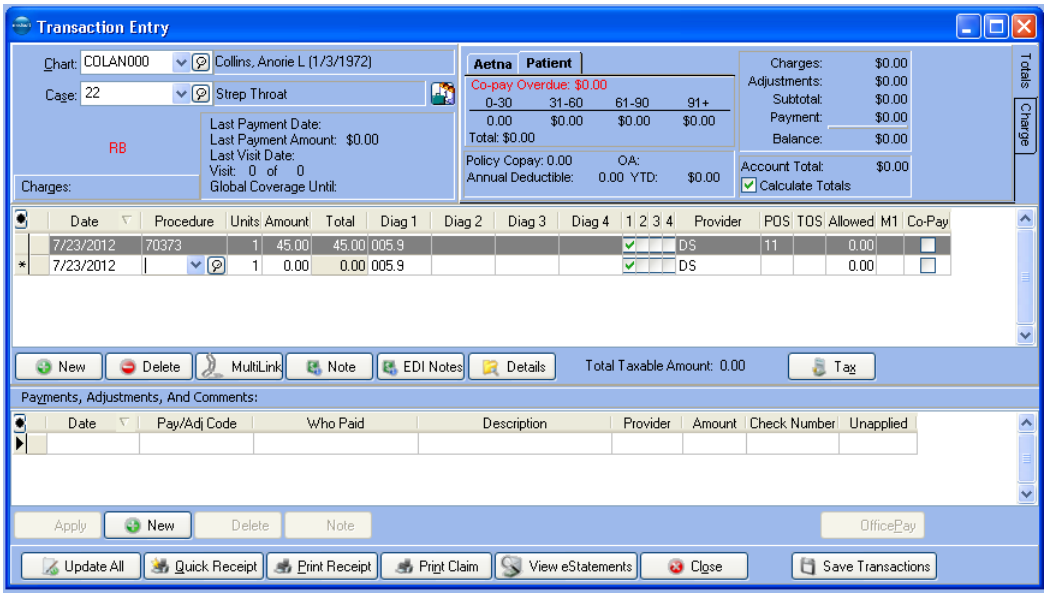

Figure 24. Transaction Entry screen

Generating Claims and Statements

Claims processing centers on the Claim Management screen from which you can create, edit, and print/send claims. Medisoft also provides support for UB-04 claims.

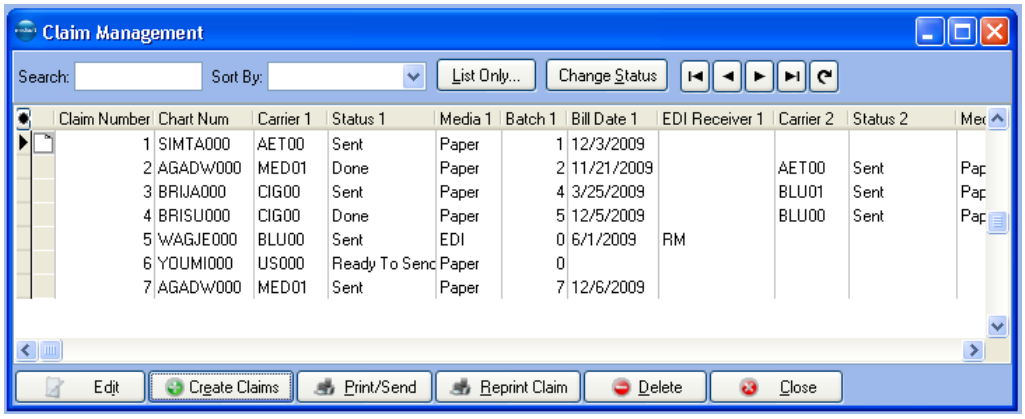

Figure 25. Claim Management screen

After you have created claims in Medisoft, you can either print them from Medisoft or file them electronically using Revenue Management (see "Electronic Claims Processing" on page 137), an integrated electronic claims filing application.

You can use the Statement Management screen (available in Medisoft Advanced or Network Professional) to create billing statements for patients.

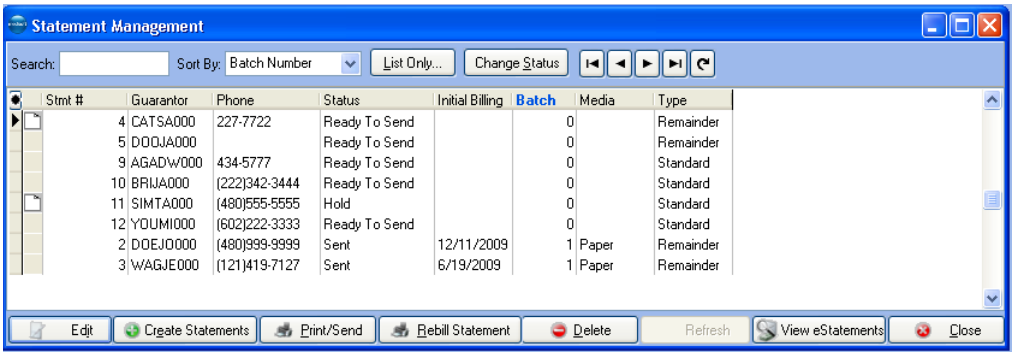

Figure 26. Statement Management screen

Chapter 3 - Creating a Practice and Setup Overview

In this chapter you will learn how to create a database for your practice and learn about program options.

Creating a Practice

The first step in setting up Medisoft is creating the database that holds the data in your practice.

Creating the Practice Database

1. When you first open Medisoft after installation, you must either create a new data set (if this is the first time you have ever installed Medisoft) or convert previous Medisoft data.

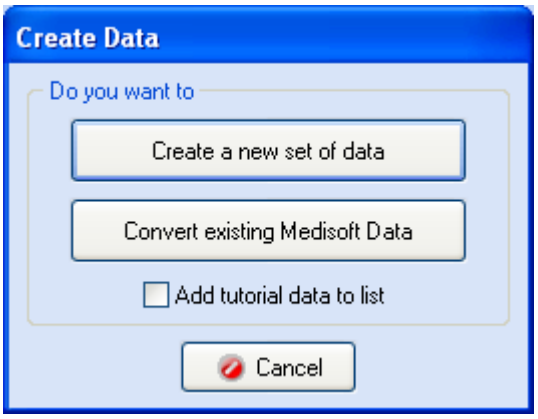

Figure 27. Create Data screen

If you have been using Medisoft Version 5.5x or 5.6x and above and have just installed Version 18, a message displays stating that data must be converted before you can access Medisoft. If you have not already created a backup on your existing data, create a backup now. Then, click **OK** to perform the automatic conversion.

If you work with multiple practices, each will have to be converted.

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2. If you choose to create a new data set, the Create a new set of data screen appears.

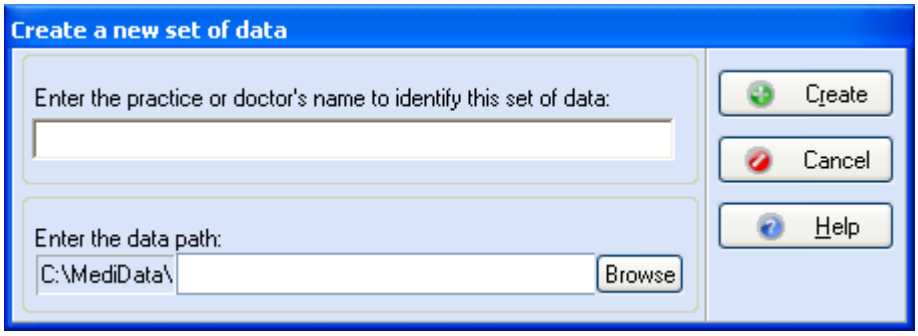

Figure 28. Create a new set of data

3. Fill in the practice name and the practice data path. The data path is the location within the MediData folder in which the practice data is stored.

4. When you click **Create**, the Practice Information screen appears. On this screen on the Practice tab, enter your basic practice information such as the name of the practice, address, and telephone number.

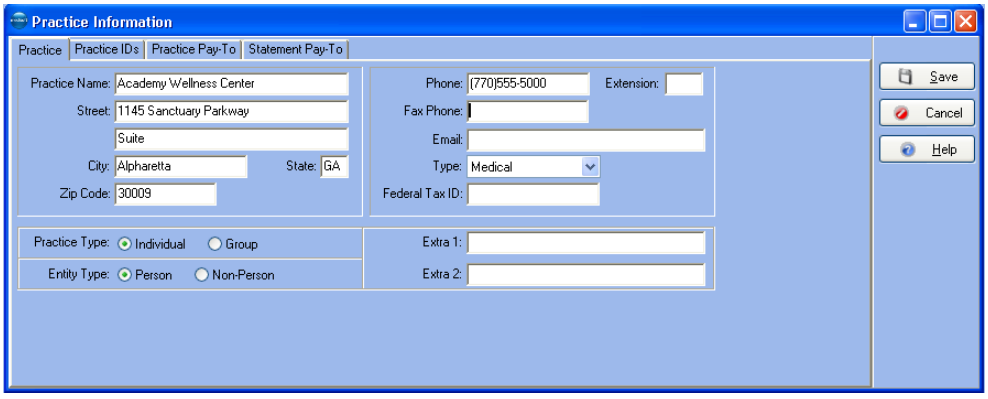

Figure 29. Practice Information screen

For more detailed information on this screen, see "Entering Basic Practice Information" on page 41.

Creating Multiple Practices

It is not necessary to install Medisoft for each new practice. When the first practice is set up, Medisoft assumes there is only one practice and establishes a default directory for the data for that practice. Each time you set up an additional data set with totally unrelated patients and procedure files, you must create a different subdirectory. This establishes a completely separate database for the new practice.

Changing the Program Date

You can change the program date for back-dating a large number of transactions. This affects all dates in Medisoft except the Date Created setting, which always reflects the System date.

Opening a Practice

To open a practice:

1. On the File menu, select the appropriate option.

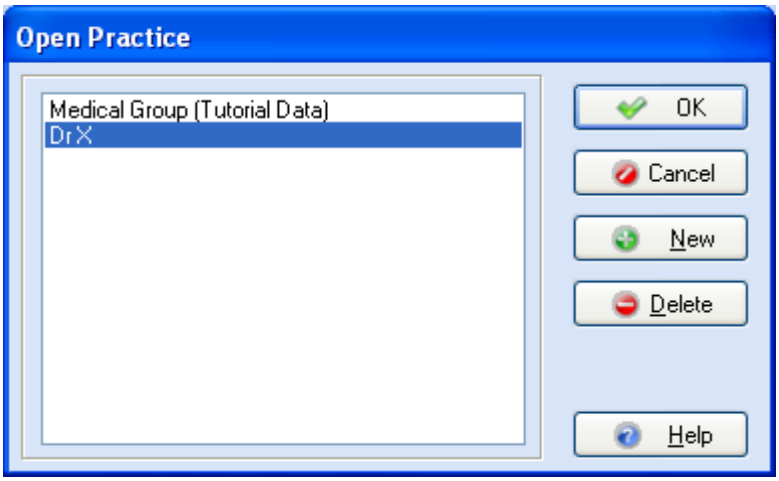

Figure 30. Open Practice screen

2. Choose the practice you want to open and click **OK**.

Setup Overview

Steps to setting up your basic practice can be found at “Entering Basic Practice Information” on page 41.

Once you have created your practice database, the next step is to enter data into each of the different areas of Medisoft, such as insurance carrier records in the Insurance Carrier screen, procedure codes in the Procedure, Payment, and Adjustment Codes screen, and so on.

Here is a sequence for practice setup that will help you enter your practice information in the most economical way.

- Creating rules overview
- Set up security
- Set up preferences
- Enter basic practice information
- Set up EDI Receivers for electronic claims and eligibility
- Enter insurance carrier records
- Enter facility records
- Enter provider records
- Enter referring provider records
- Enter other address records
- Enter procedure codes and multi-link codes
- Enter diagnosis codes
- Enter billing codes
- Enter guarantor and patient records

Keeping in mind your practice structure and your filing needs will help you set up your practice.

Creating Rules Overview

Medisoft claim processing for both print and electronic claims depends on a series of flexible rules that you define. When setting up your practice, you will create a series of grid entries (rules) on the Practice IDs screen (see “Entering a Practice IDs Rule” on page 42) and Provider IDs screen (see “Entering Provider IDs Rules” on page 49). Depending on your practice, you may also use the Facility IDs screen (see “Entering Facility Information” on page 63) and Referring Physician IDs screens (see “Entering Referring Provider Rules” on page 55). These rules contain your basic practice information, such as group or individual NPI numbers, taxonomy, tax IDs, and claim filing status (group or individual). They also connect this information to the insurance companies that your patients use and the physicians in your practice.

You begin by creating rules for each provider on the Provider IDs screen and at least one rule on the Practice IDs screen. These rules will contain information that would apply to the most generic situations. Then, you will create other rules that apply to a specific insurance company, insurance

category, facility, provider, and so on. See “If you are a solo provider (file claims as an individual)” on page 26 and “If you are a group (file claims as a group)” on page 29 for more detailed information.

When you create claims using Revenue Management, Medisoft gathers data for each claim using these rules, looking first at rules that apply to an insurance company or provider. It will compare these rules against rules set up for facilities or referring physicians. The specific order in which Medisoft analyzes rules follows the order of fields on the level it is working on. For instance, when looking at practice information, it will look first at Providers, then Insurance Carrier, and so on, moving from left to right on the grid.

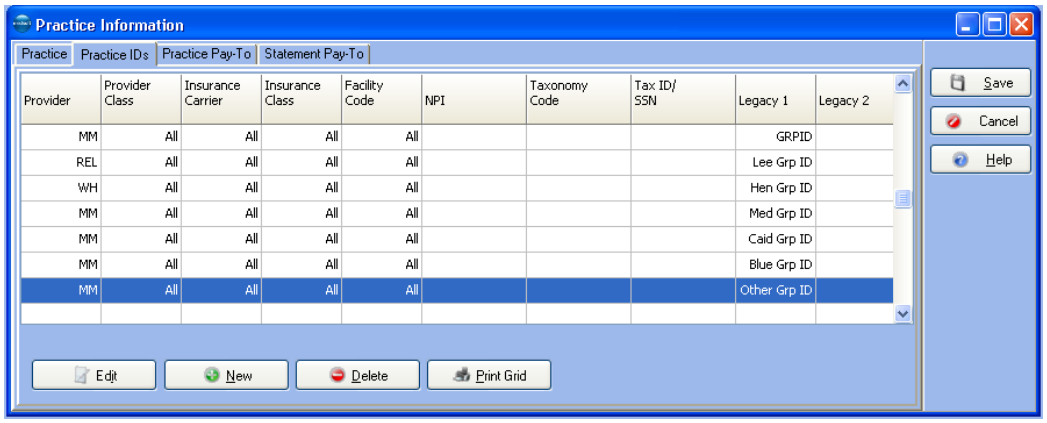

Figure 31. Practice IDs screen with grid headings highlighted

For instance, if you are setting up a group practice with three physicians,

1. Create at least one rule on the Practice IDs screen for general information that is common to all claims. Apply this rule to all providers, all insurance companies, and all facilities (assuming you have no facilities associated with your practice or all facilities would use the same details). Include your group NPI, taxonomy, and tax ID numbers.
2. Second, create one rule on the Providers IDs screen for each provider (a total of three rules). You must include one rule for each provider on the Provider IDs screen since claim filing status (individual or group) is specified there. Each of these rules would be general and could apply to all insurance companies and facilities. Select Group for your claim type and select From Practice to pull NPI, taxonomy, and Tax IDs from the Practice IDs screen.
3. If one of the insurance companies requires a legacy identifier, create a second entry on the Practice IDs screen. By creating a second entry on this screen instead of the Provider IDs screen, you save time and effort. This one rule can be applied to all the providers at the practice level, instead of creating a rule for each provider at the provider level. To do this, for this second Practice IDs rule, select the *specific* insurance company and select *all* providers. Importantly, include your NPI, taxonomy, and Tax IDs since each rule needs to be complete. Finally, enter the legacy number the insurance company requires. When the application gathers claim data, it will select this row for the specific insurance company and pull the data for the claim.

If you are a solo provider (file claims as an individual)

As a solo provider, you have two options when entering key ID numbers, such as NPI, taxonomy, and tax ID/social security number.

- Enter this information at the practice level using the Practice IDs screen (see "Entering a Practice IDs Rule" on page 42). With this method, enter these numbers on the Practice ID screen. Then, select From Practice for all values on the Provider IDs screen (see "Entering Provider IDs Rules" on page 49).

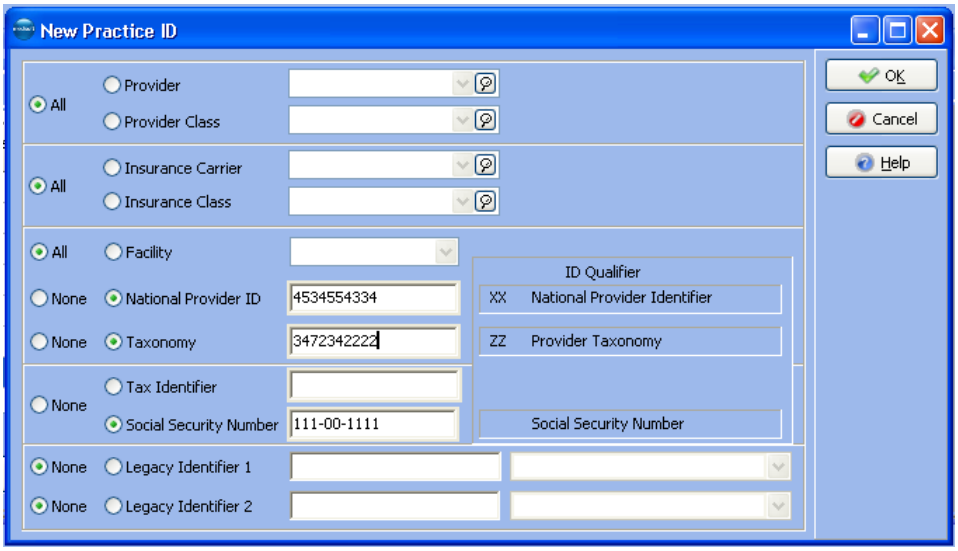

Figure 32. New Practice ID screen

Enter this information at the provider level using the Provider IDs screen (see "Entering Provider IDs Rules" on page 49). In this case, on the Practice IDs screen, select None for NPI, taxonomy, tax ID/social security number, and so on, and enter a minimal amount of information. Then, on the Providers screen, specify your NPI, taxonomy, tax ID/social security number, and so on. Also,

select Individual for the File Claim as.The result will be the same and Medisoft will correctly pull these IDs when filing claims.

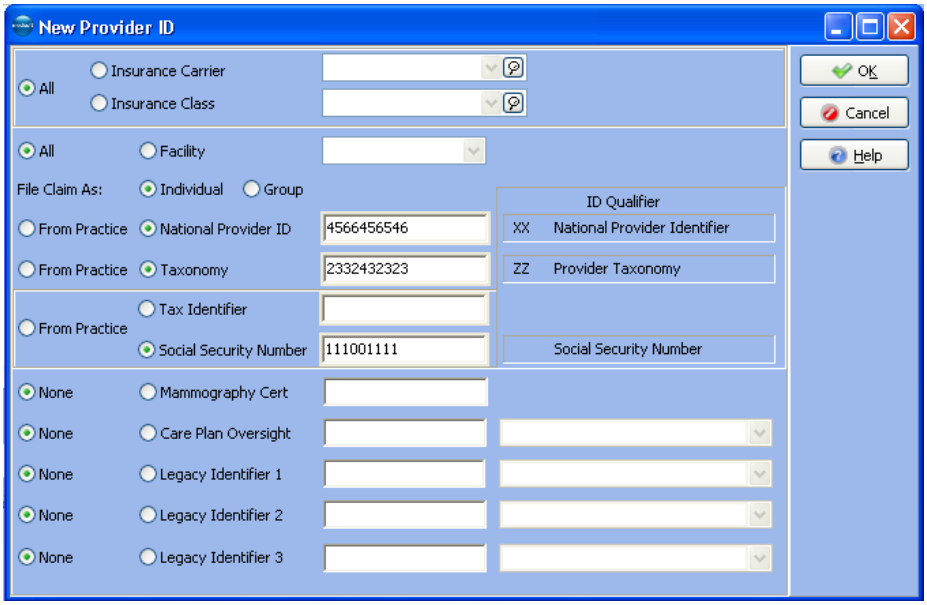

Figure 33. New Provider IDs screen

NPI Considerations

If you have the same pay-to address as your billing address, you can enter your NPI information on the Practice IDs screen. Then, select From Practice on the Providers IDs screen. This will ensure that the NPI number appears on all claims.

If you have different billing information and pay to information (see “Entering Practice Information for a Billing Service” on page 44), enter your NPI information on the Practice IDs screen. Also, enter any unique NPI on the Provider IDs screen.

If you have insurance companies that require mixed NPI numbers (some require individual while some require group), enter your *group* NPI number on the Practice IDs screen. Then, create several rules on the Provider IDs screen specific to the insurance companies that require mixed NPI numbers. For insurance companies that require the group NPI, select From Practice for the NPI number. This will pull that number from the Practice IDs screen. For insurance companies that require an individual NPI number, select National Provider ID and enter the number on the Provider IDs screen.

Insurance Company Considerations

You might only need one rule (grid entry). Most likely though, you will probably have at least one or more insurance companies that require different information. In that case, you must create other rules that are specific to that insurance company and the information needed, for instance a legacy

qualifier such as a medicare number, as shown in ***Figure*** 34.

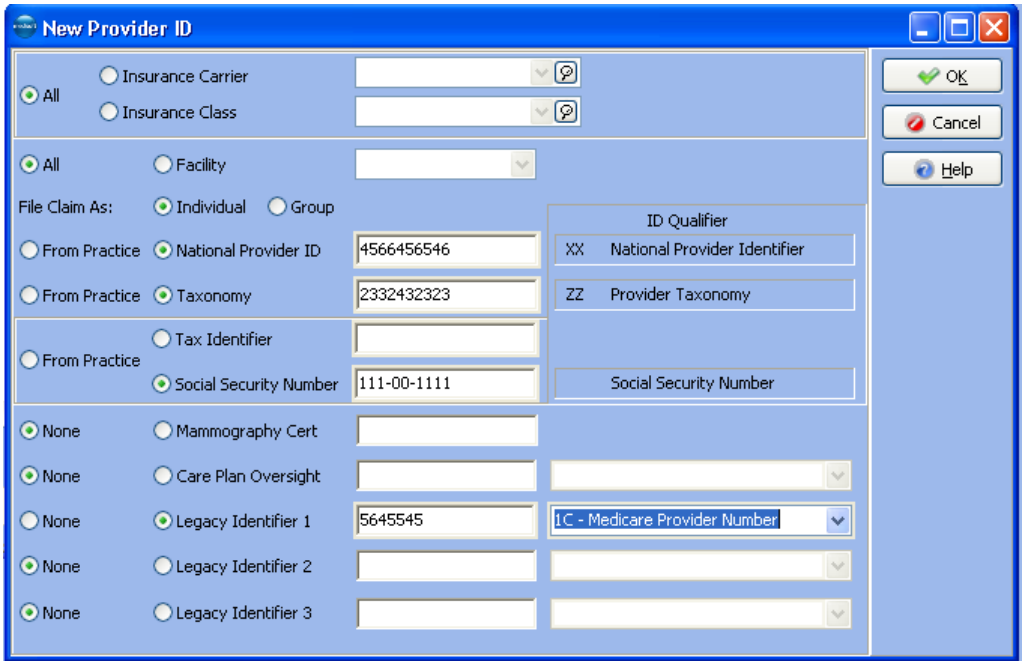

Figure 34. Edit Provider IDs screen, specific to an insurance company

Each of these additional rules needs to be complete since the claims processing pulls all the information in a rule and not just one field. An incomplete rule (for instance, no NPI number) will leave fields empty in the claim, causing rejection. In the case of ***Figure*** 34, you would need to include the NPI number, Taxonomy number, and Social Security Number since those were included in the initial rule using the Provider IDs screen (see ***Figure*** 33). If you used the Practice IDs screen, you could select From Practice for these numbers and you would not need to specify them on the Provider IDs screen since Medisoft would pull these values from the Practice IDs screen.

If an insurance company requires taxonomy, you must create a rule on the Practice IDs screen for that insurance carrier and enter the taxonomy number there. Then, open the Insurance Companies screen and select the Send Practice Taxonomy in Loop 2000A checkbox. If your practice requires dual taxonomy, then you must also create a rule on the Provider IDs screen for that number, specifying the provider and insurance company.

Facility Considerations

If you have facilities attached to your practice, you must create rules on the Facility ID screen for any numbers that are specific to that facility. If you have entered a separate NPI number for a facility and need to send facility billing information, specify the type of facility and qualifier, including the unique facility NPI number. If this information is sent on the claim, select the Send Facility on Claim check box and do not include any other data.

Referring Physician Considerations

If your practice has referring physicians, create records for them on the Referring Physicians screen and use the Referring Physician IDs screen to enter any numbers unique to a referring physician.

If you are a group (file claims as a group)

First, complete at least one rule on the Practice IDs screen for the practice. Then, create at least one rule on the Provider IDs screen for each provider. Set your claim filing status on the Provider IDs screen by selecting Group for each provider in your practice.

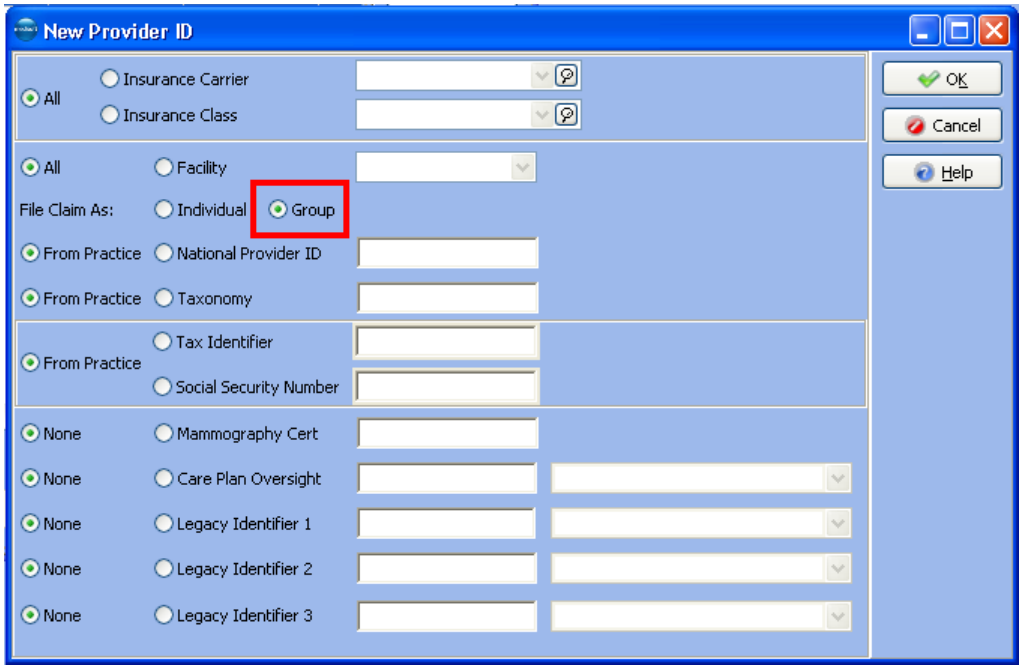

Figure 35. New Provider IDs screen with Group selected

If you have a provider that files claims using a personal NPI number for a specific insurance company, create an extra rule for this provider, specifying that particular insurance company. Enter the unique NPI number for that rule.

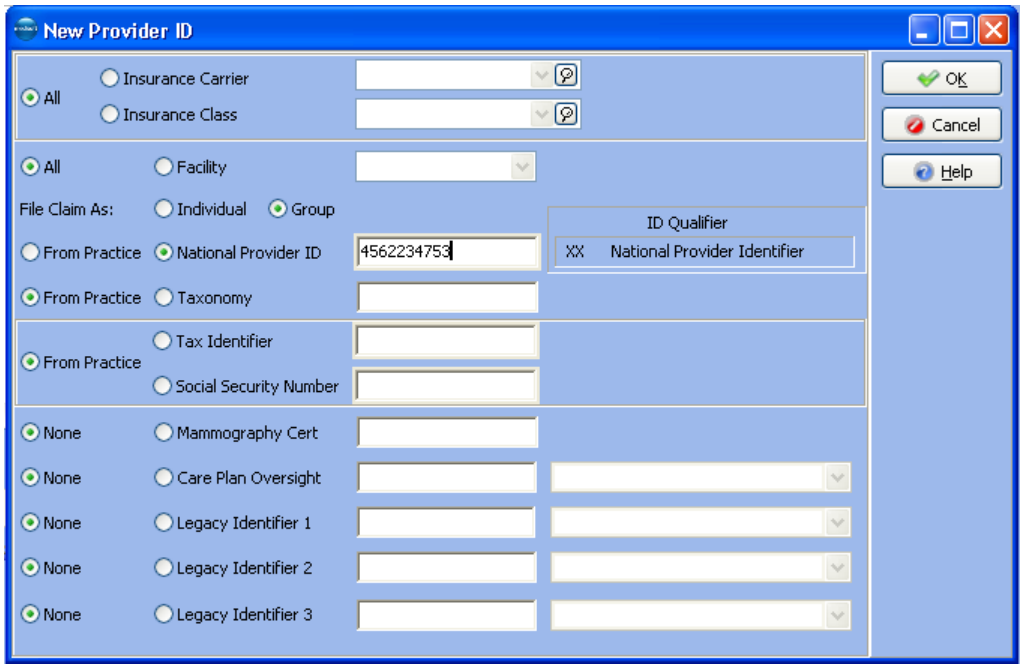

Figure 36. New Provider IDs screen with NPI for specific insurance company

NPI Considerations

Enter your NPI information on the Practice IDs screen. Then, on the Provider IDs screen, select From Practice.

If you have insurance companies that require mixed NPI numbers (some require individual while some require a group), enter your *group* NPI number on the Practice IDs screen. Then, create several rules on the Provider IDs screen specific to the insurance companies that require mixed NPI numbers. For insurance companies that require the group NPI, select From Practice for the NPI number. This will pull that number from the Practice IDs screen. For insurance companies that require an individual NPI number, select National Provider ID and enter the number on the Provider IDs screen.

Insurance Company Considerations

If an insurance company requires dual taxonomy, you must create a rule on the Practice IDs screen for that insurance company and enter the taxonomy number there. Then, open the Insurance Companies screen and select the Send Practice Taxonomy in Loop 2000A checkbox.

Most likely though, you will probably have at least one or more insurance companies that require different information. In that case, you must create other rules that are specific to that insurance company and the information needed, for instance a legacy qualifier such as a medicare number, as shown in ***Figure*** 37.

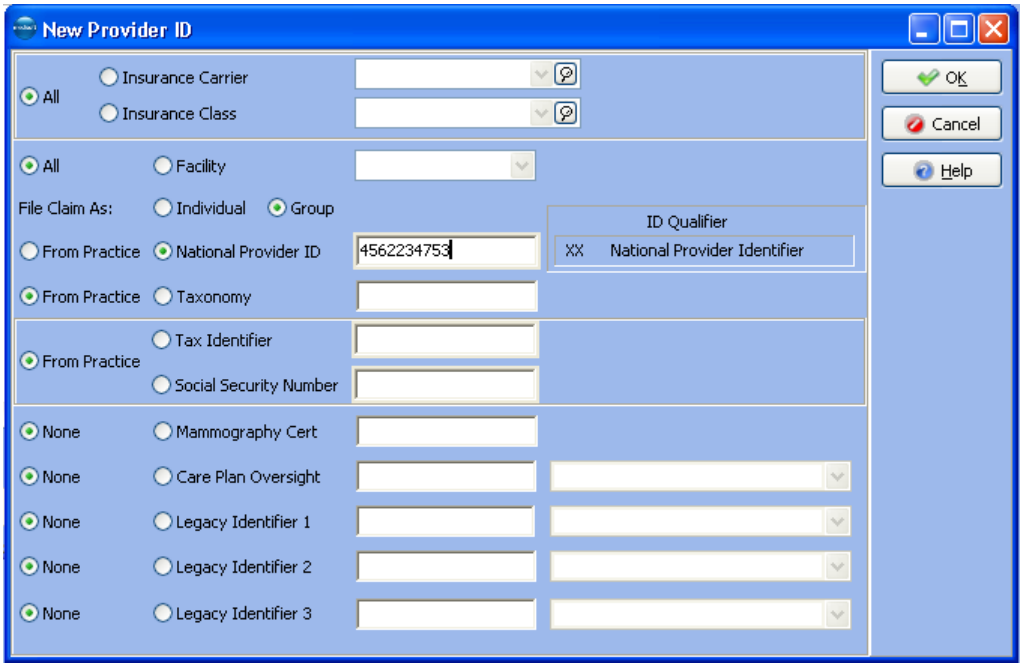

Figure 37. New Provider IDs screen, specific to an insurance company

Each of these additional rules needs to be complete since the claims processing pulls all the information in a rule and not just one field. An incomplete rule (for instance, no NPI number) will leave fields empty in the claim, causing rejection. In the case of ***Figure*** 37, you would need to include the NPI number, Taxonomy number, and Social Security Number since those were included in the initial rule using the Provider IDs screen (see ***Figure*** 36). If you used the Practice

IDs screen, you could select From Practice for these numbers and you would not need to specify them on the Provider IDs screen since Medisoft would pull these values from the Practice IDs screen.

Facility Considerations

If you have facilities attached to your practice, you must create rules on the Facility ID screen for any numbers that are specific to that facility. If you have entered a separate NPI number for a facility and need to send facility billing information, specify the type of facility and qualifier, including the unique facility NPI number. If this information is sent on the claim, select the Send Facility on Claim check box and do not include any other data.

Referring Physician Considerations

If your practice has referring physicians, create records for them on the Referring Physicians screen and use the Referring Physician IDs screen to enter any numbers unique to a referring physician.

Setting Program Options

The Program Options screen contains various default settings that affect operations in different parts of the program.

To open Program Options:

- On the File menu, select **Program Options**.

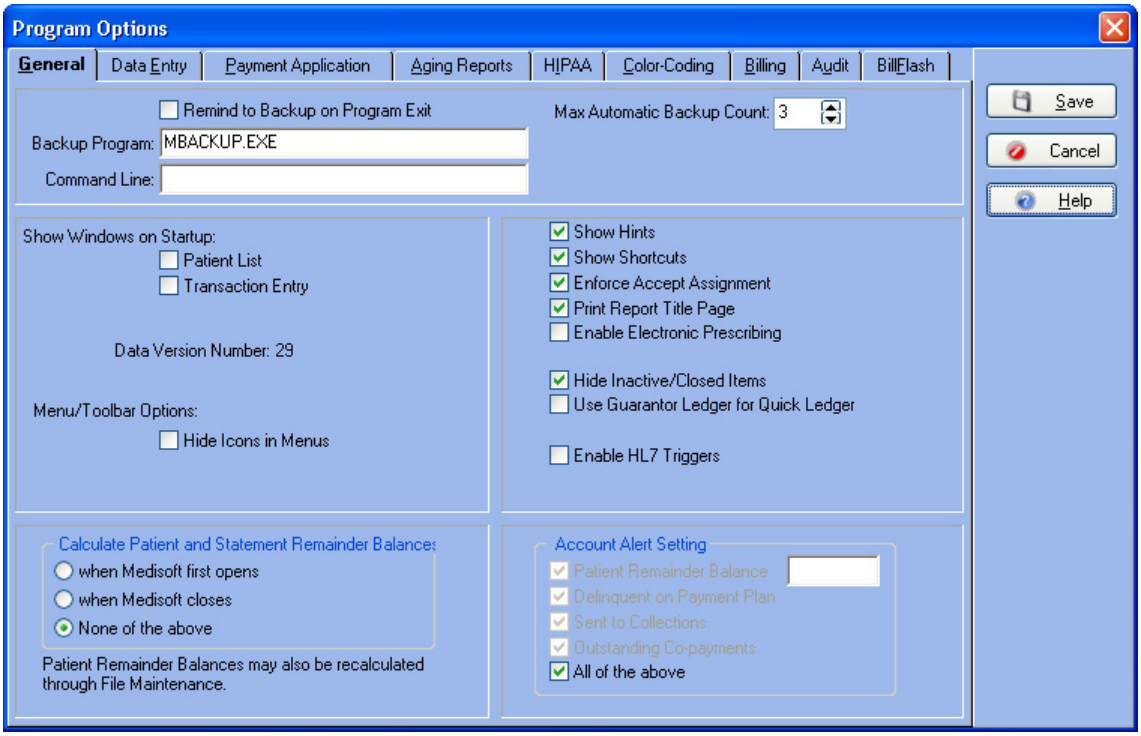

Figure 38. Program Options screen

TIP: For most users the default settings on the various tabs on the screen are sufficient for initial use. You can customize these settings at a later date.

- Each tab features settings for different functional elements in the application. For more information on the available options and settings, see:
- “General Tab” on page 169
- “Data Entry Tab” on page 170
- “Payment Application Tab ” on page 171
- “Aging Reports Tab” on page 172
- “HIPAA Tab” on page 173
- “Color-Coding Tab ” on page 174
- “Billing Tab ” on page 175
- “Audit Tab ” on page 176

- “BillFlash Tab ” on page 177

Chapter 4 - Security Setup Overview

Basic security in Medisoft is practice-based, with each practice having various users and groups. Multiple practices require security setup for each database. Setting up security is a two-step process:

1. Create users, giving them a login name, password, and access level (1-5).

   The access level determines which areas of the practice a user can access. Level 1 users have the most access, while Level 5 users have the least access.

   The first user you will create is the system administrator, who must be a level 1 and have access to all areas of the practice.

2. Assign permissions to users, using the five access levels.

Creating Users

You create users of the practice in the User Entry screen. To create a practice

1. On the File menu, select **Security Setup**. The Security Setup screen appears. This screen shows you a list of all users.
2. Click **New**. The User Entry screen appears.

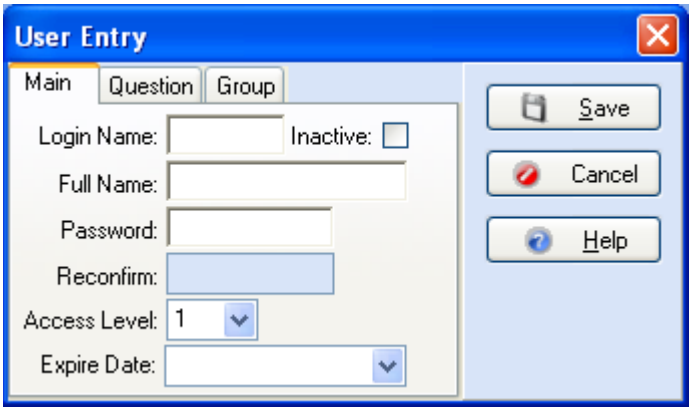

Figure 39. User Entry screen

3. Complete the fields on the screen.

4. Click **Save**. The Security Setup screen appears and shows you the new user.

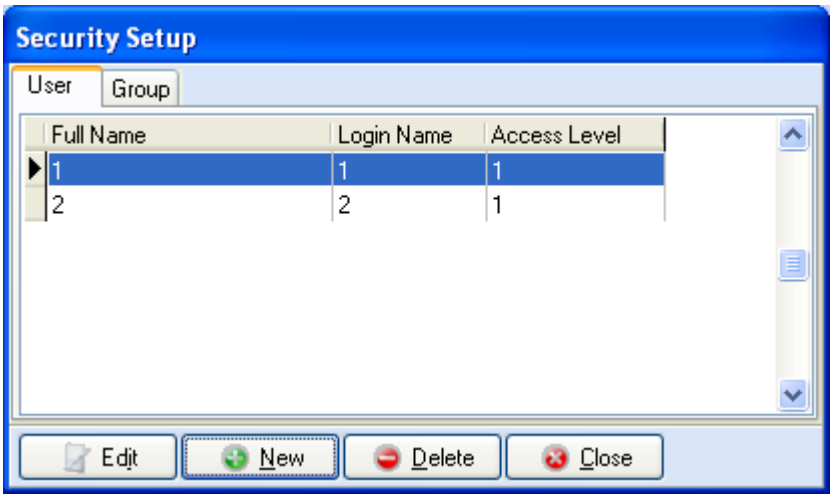

Figure 40. Security Setup screen

Login/Password Management

Use Login/Password Management to set the requirements and application of login rights and password usage. For example, you can set the length of valid passwords, the valid time frame in which a password can be used before it has to be changed, how long a user has to wait before reusing a password, and so on.

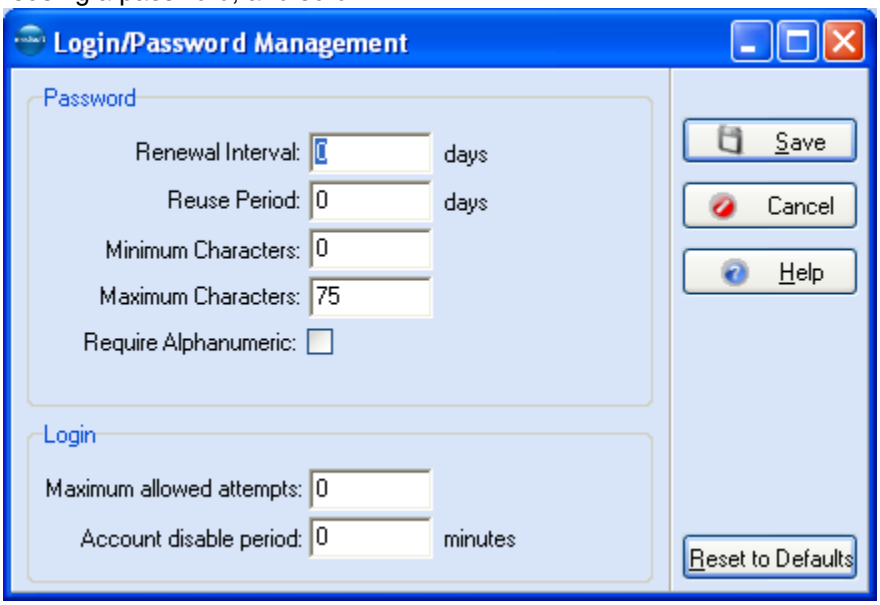

Figure 41. Login/Password Management screen

Setting Permissions

NOTE: This is an Advanced or Net Pro feature.

The Permissions feature provides five levels of access to Medisoft. Once you have created at least one user for your practice and logged into your practice using someone's login and password, the Permissions options will be available.

To set permissions:

1. On the File menu, select **Permissions.** The Medisoft Security Permissions screen appears.

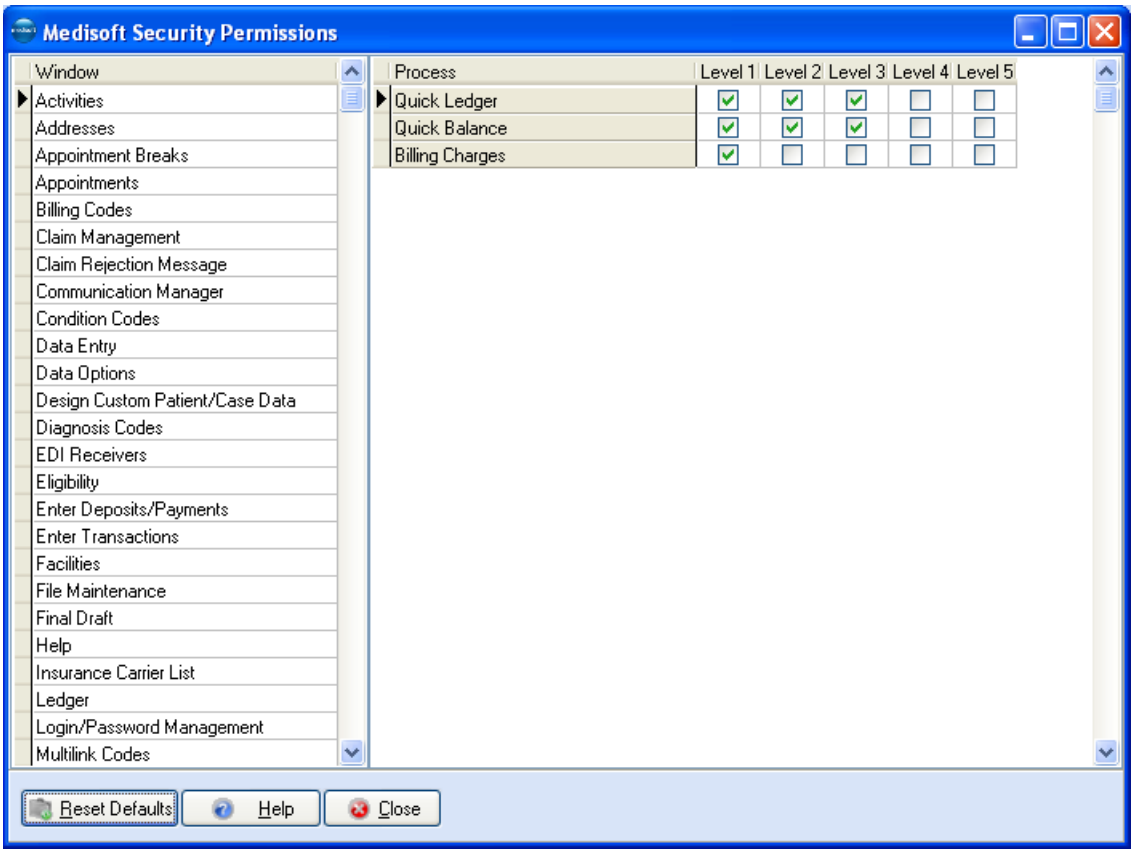

Figure 42. Medisoft Security Permissions screen

This screen comprises two sections:

- The screen section displays all the areas of the practice for which security can be set up.
- The Process section shows the individual elements, features, or screens that make up the selected area in the screen section.

  Level 1 is for unlimited access and is designed to be used exclusively by the Supervisor or administrator to restrict access to Medisoft. For Levels 2, 3, 4, and 5, the supervisor defines what access goes with each level and assigns users based on that.

2. Select a program area in the **screen** section. The options for that area appear in the **Process** section.
3. Select or clear check boxes for each option and level in the Process section of the screen.
4. Click **Close** when you are done.

The Security Supervisor, who has unlimited access and full control of security, can assign or remove rights for any level of security, with one exception. Level 1 access cannot be removed from any of the three options listed in the Process section of the Permissions screen when Security is selected in the screen section.

Chapter 5 - Entering Practice Information

Enter basic practice information that the system uses for reports, statements, and filing claims. Be sure to enter complete information so that your claims will be complete.

Entering Basic Practice Information

To enter practice information:

1. On the File menu, select **Practice Information**. The Practice Information screen appears.

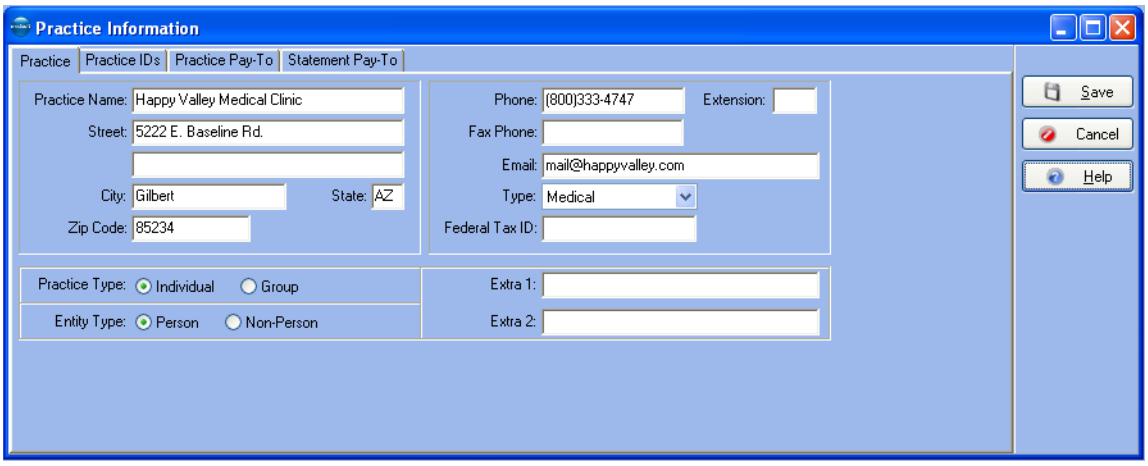

Figure 43. Practice Information screen

2. On the Practice tab, enter the contact information for the practice. The address must be a physical address, not a P.O. Box. If you have a P.O. Box to which payments are sent, that information will go in the Practice Pay-To tab.
3. From the Type list select your practice type.
   When you select **Chiropractic**, the Level of Subluxation field appears in the Diagnosis tab of the Case screen for entering the level of subluxation. In addition, five treatment fields are displayed in the Miscellaneous tab of the Case screen.
4. In the Federal Tax ID field, enter the practice's federal tax ID.
5. From Practice Type, select **Individual** or **Group**.
6. From Entity Type, select **Person** or **Non-Person**.

NOTE: Extra 1 and Extra 2 are optional fields that may be used if a carrier requires extra data on a claim. They can hold up to 30 characters.

Entering a Practice IDs Rule

Use the Practice IDs tab and Practice IDs grid to enter or edit key data elements associated with your practice (tax ID/social security number, NPI, taxonomy, legacy numbers). You will set up at least one rule on the Practice IDs grid and associate this information to all providers, insurance carriers, and all facilities. For more information on entering data on the IDs grid, see "Creating Rules Overview" on page 24.

1. Select the **Practice IDs** tab.The Practice IDs tab appears.

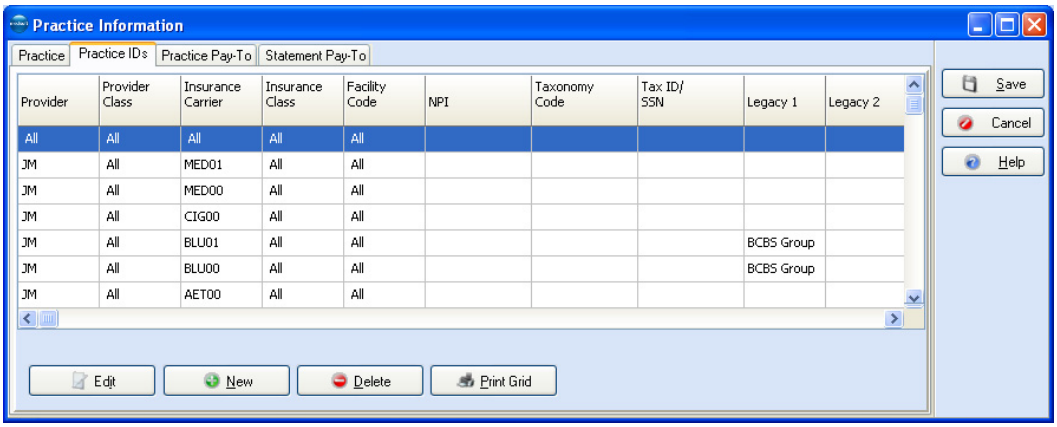

Figure 44. Practice IDs screen

2. Click the **New** button to create a new rule.

   --OR--

   To edit an entry, select the record on the grid and click **Edit**.

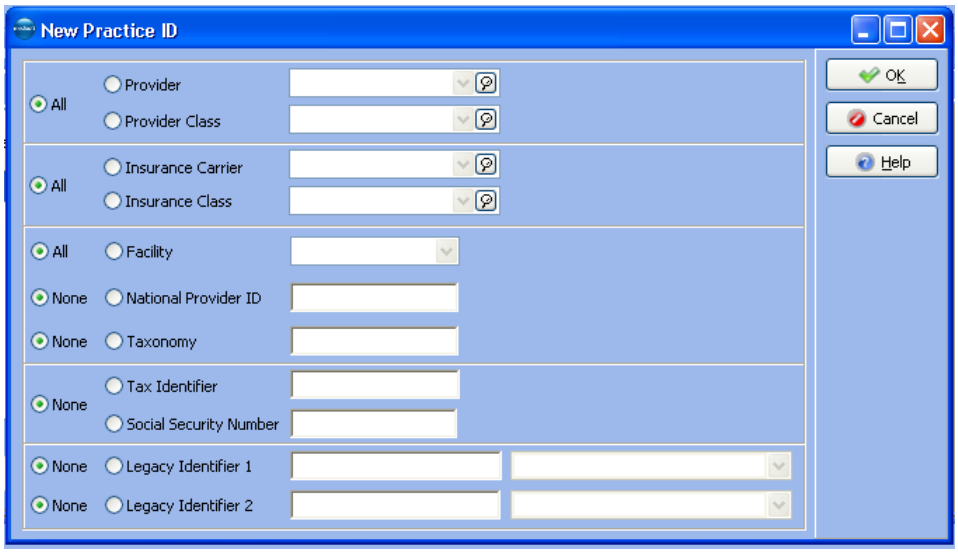

Figure 45. New Practice ID screen

3. Select the **All**, **Provider**, or **Provider Class** button.

4. Select the **All** button to apply the rule to all providers associated with the practice.

   To apply the rule to a specific provider, select the **Provider** button and click the magnifying glass to select the specific provider.

   To apply the rule to a specific provider class, select the **Provider Class** button and click the magnifying glass to select the provider class.

5. Select the **All**, **Insurance Carrier**, or **Insurance Class** button.

   Select the **All** button to apply the rule to all insurance carriers associated with the practice.

   To apply the rule to a specific insurance company, select the **Insurance Carrier** button and click the magnifying glass to select the insurance carrier.

   To apply the rule to a specific insurance class, select the **Insurance Class** button and click the magnifying glass to select the insurance class.

6. Select either the **All** or **Facility** button.
7. Select National Provider ID and enter an NPI number to associate that NPI number with the rule.

TIP: if your practice has a group NPI number, enter it here. Then, if providers in your office need to file claims as individuals, you can create a rule for that provider using the provider's individual NPI number that you enter on the Provider IDs grid.

8. Select either **None** or **Taxonomy**.
9. Select the **Tax Identifier** button and enter the tax ID number to associate with the rule.
10. Select the **Social Security Number** button and enter the social security number to associate with the rule.
11. If needed, enter up to two legacy numbers and qualifiers to associate with the rule using the Legacy Identifier 1 and 2 fields. Use these fields to customize your rule to meet filing requirements with an insurance carrier(s).
12. Click **Save**.

Entering Practice Information for a Billing Service

Billing Services

If you are a billing service, enter your client's information in the Practice tab. Enter your information in the Practice Pay-To tab. If you want to use Medisoft to keep track of your own accounts receivables, a separate database can be set up with each client listed as a patient. Separate procedure codes can be created to cover the various services of your billing service.

To set up a billing service:

1. On the File menu, select **Practice Information**. The Practice Information screen appears.
2. Select the **Practice Pay-To** tab.

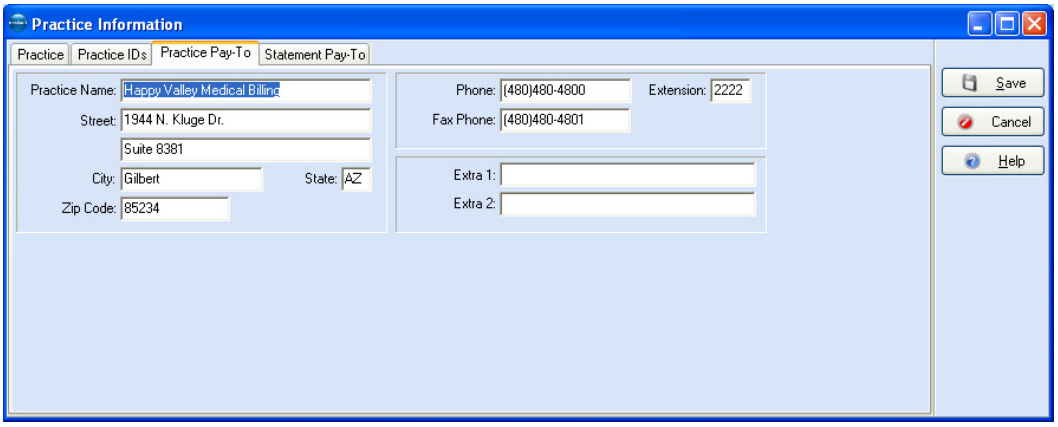

Figure 46. Practice Information screen, Practice Pay-To tab

3. Enter the pay to information in the Practice Name, Street, City, State, Zip Code fields.
4. Click **Save**.

BillFlash Users

BillFlash is the online service available to you if you want to send your statements electronically. Once you enroll with BillFlash, you can create statements and upload them to BillFlash. BillFlash then takes care of printing and sending them to your patients.

If you use Bill Flash for electronic statement processing, complete the Statement Pay To tab. Data on this tab is used to create a separate pay-to address location for the statements, for instance, a PO Box instead of a physical address.

To complete the Statement Pay-To tab:

1. On the File menu, select **Practice Information**. The Practice Information screen appears.

2. Select the **Statement Pay-To** tab.

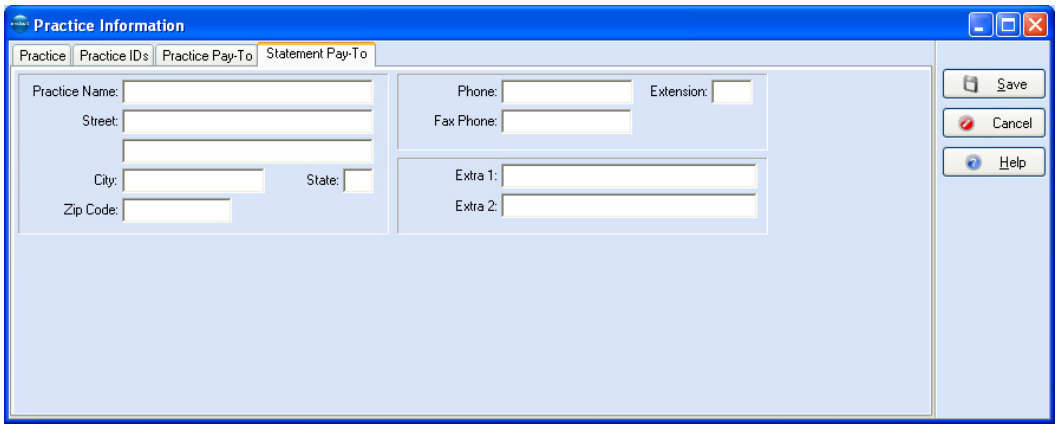

Figure 47. Practice Information screen, Statement Pay-To tab

3. Enter the pay to information in the Practice Name, Street, City, State, Zip Code fields.

NOTE: the Extra 1 and Extra 2 fields are only used if a carrier requires extra data on a claim.

4. Click **Save**.

EDI Receiver Records

The EDI Receiver screen displays parameters used for transmitting information to a clearinghouse.

To open the EDI Receiver screen:

- On the Lists menu, select **EDI Receivers**.

The settings in Medisoft on the EDI Receiver screen are used for setting rules for electronic claims generation. The actual transmission of claims is done by Revenue Management. If you make changes on these tabs in Medisoft, the changes flow automatically to Revenue Management, and changes made there are also transferred to Medisoft.

When sending electronic claims, set up your clearinghouse or direct payors in Revenue Management. Once an EDI receiver is set up, Revenue Management will synchronize the EDI settings in Medisoft. For users upgrading to Medisoft 18, Revenue Management can use the existing settings for the payors set up on the EDI Receiver screen, but you will need to reconfigure receivers to work with Revenue Management.

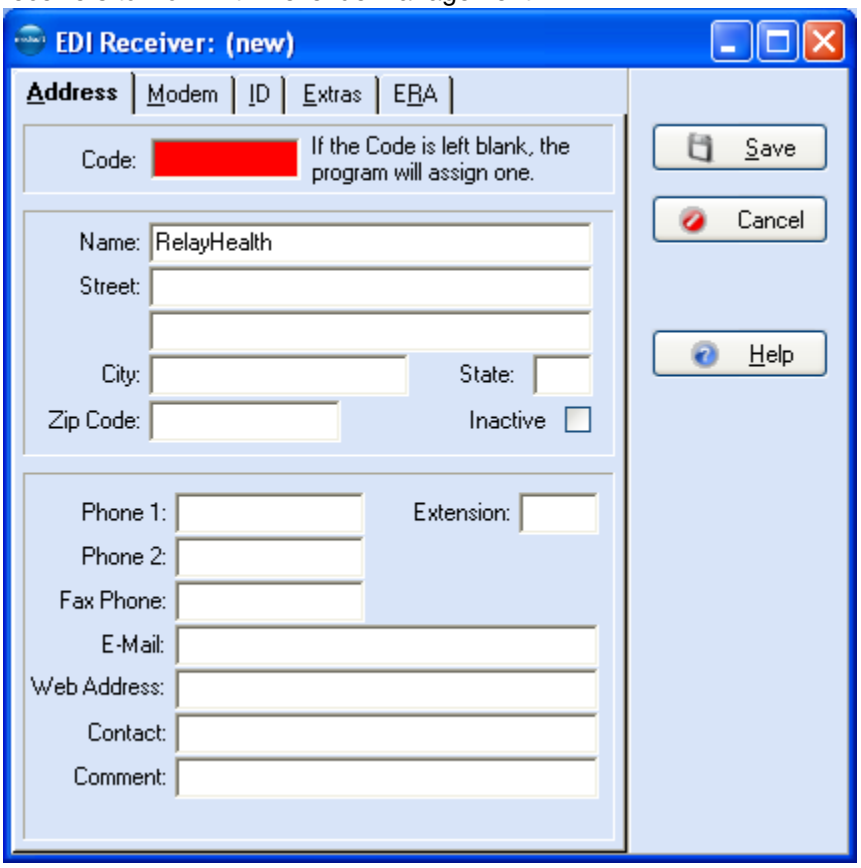

Figure 48. EDI Receiver screen

Chapter 6 - Setting up Providers and Provider Classes

Set up your providers (physicians) in Medisoft so you can add them to patient records and transactions entered. In this way their information will be put on claims.

Entering Provider Information

Enter provider records on the Providers screen. To do so

1. On the Lists menu, select **Provider.**
2. Then, select **Providers**. The Provider List screen appears. This screen shows you all of the providers currently set up in the practice.

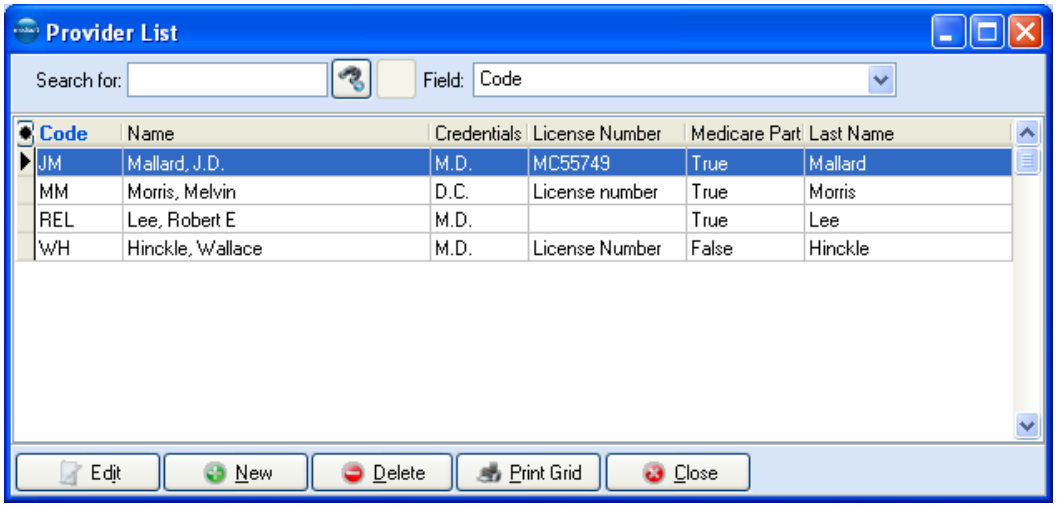

Figure 49. Provider List screen

3. Click **New**.

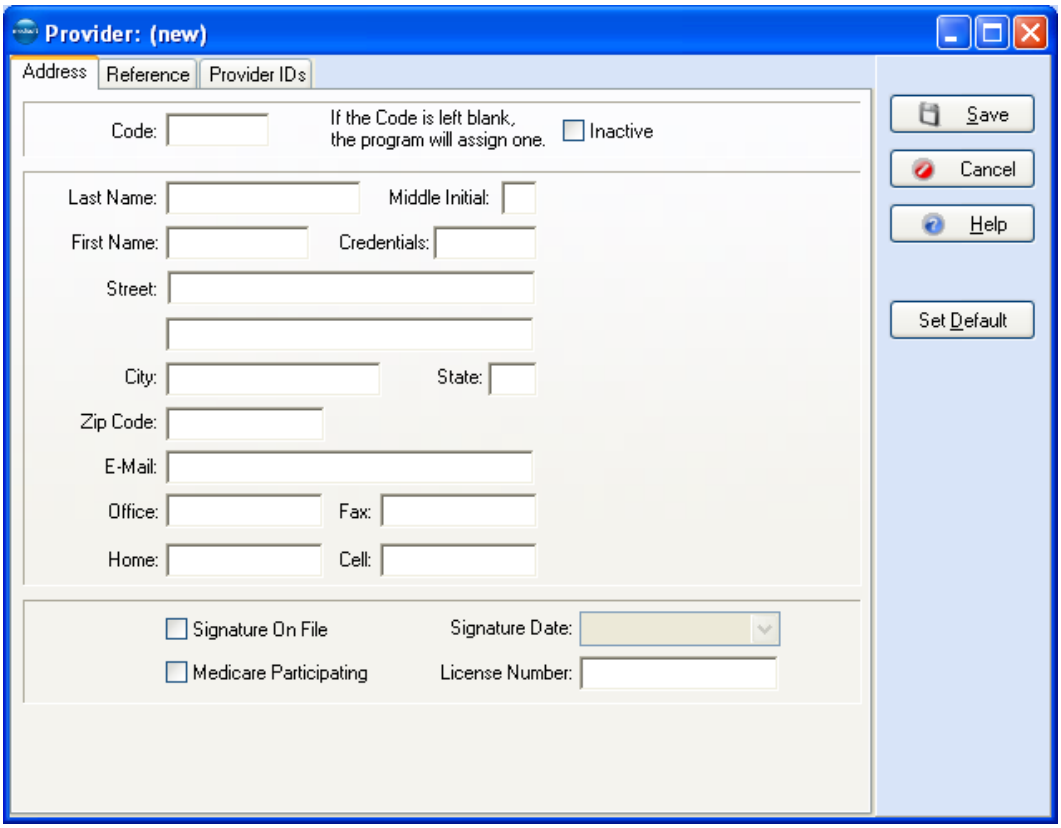

Figure 50. Provider screen

4. On the **Address** tab, enter demographic information for the provider such as last name, first name, title.
5. Options:

   Select the Medicare Participating check box if the provider is considered a Medicare participating provider. A Medicare participating provider agrees to accept assignment on all Medicare claims for covered services and supplies. This field is generally used with electronic claims.

   Select the Signature on File check box to indicate that the provider's signature is on file. Select this box if the provider has signed an agreement with Medicare to accept its charges and an affidavit is on file. If it is checked, the Signature Date field becomes active to display the date on which the signature was placed on file. Enter a date in this field.
6. In the License Number field, enter the provider's license number.
7. Click **Save** if you are finished with the record or click the Reference tab.

   The Reference tab displays data and values before the data was converted to Medisoft 18 and moved to the Provider IDs grid to create rules for claim creation. The tab shows data from the Default Pins and Default Group IDs tabs, which were replaced with the Provider IDs tab.

This tab is mostly used for reference purpose only. You can update data on this tab for your reference purposes, but none of this data is pulled for claim generation. The only field that still impacts claims is Provider Class.

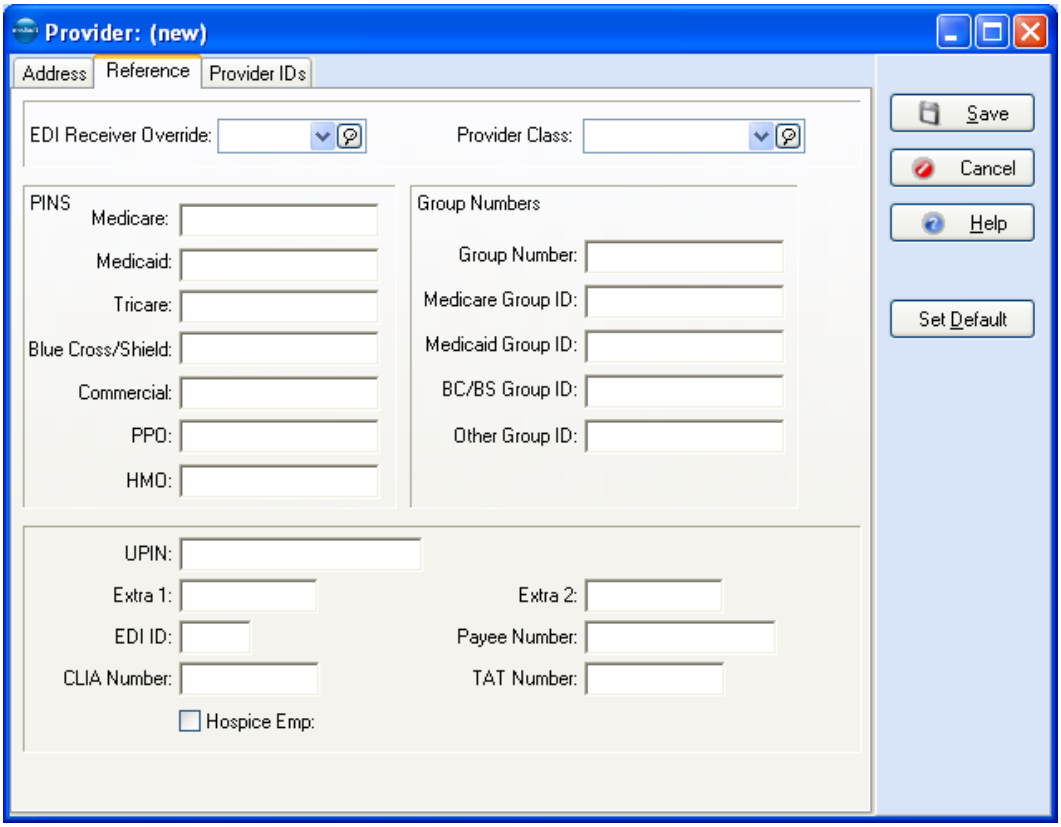

Figure 51. Provider screen, Reference tab

8. Assign a provider to a provider class by clicking the Provider Class list and selecting a class.

NOTE: Provider classes are set up in the Provider Class screen.

When generating claims, you can use the provider class on the Practice IDs tab to limit a rule to a specific class of providers.

9. Click **Save** if you are finished with the record or select the Provider IDs tab.

Entering Provider IDs Rules

Use the Provider IDs tab to enter or edit key data associated with a provider (tax ID/social security number, NPI, taxonomy, legacy numbers). Set up at least one rule on the Provider IDs grid for each provider in your practice and associate this information to all insurance carriers or insurance classes and all facilities or a particular insurance carrier or an insurance class.

For information on creating these rules, see “Creating Rules Overview” on page 24.

To enter rules for a provider:

1. Select the **Provider IDs** tab.

2. Click **New** to create a new rule.

   --OR--

   To edit a rule, select the record on the grid and click **Edit**.

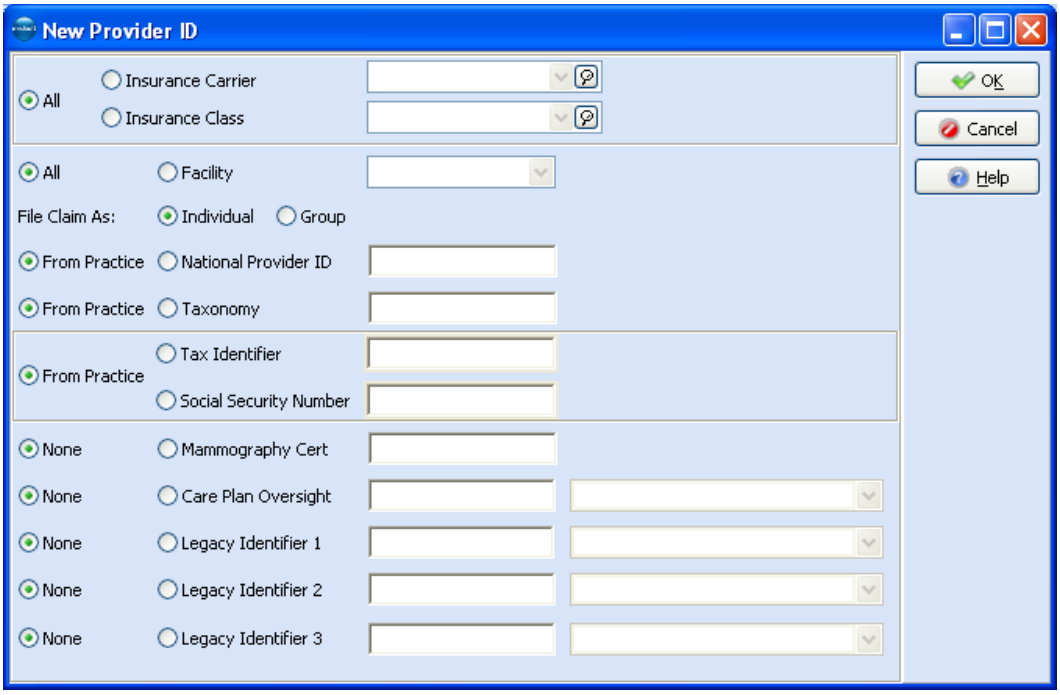

Figure 52. New Provider ID screen

3. Select either **All, Insurance Carrier,** or **Insurance Class**. Select a carrier or class if necessary.
4. Select either **All** or **Facility**. Select a facility if necessary
5. Select either File Claim As **Individual** or File Claim As **Group**.
6. Select either From Practice or National Provider ID. Enter an ID if the NPI is for this provider only.

   If you do not want to send an NPI number on a claim, select From Practice and then on the Practice IDs screen, create a matching entry for the provider in which you select None for the NPI option.

7. Select the From Practice button to pull the NPI number from the Practice IDs grid.

WARNING: By selecting From Practice for the NPI, it will put the Practice NPI in the Rendering Provider in Loop 2310.

8. Select either From Practice or Taxonomy.

   If you do not want to send a taxonomy number on a claim, select From Practice and then on the Practice IDs screen, create a matching entry for the provider in which you select None for the Taxonomy option.

Select the From Practice button to pull the taxonomy number from the Practice IDs grid.

9. Select From Practice, Tax Identifier, or Social Security Number. Select From Practice to pull the tax ID/social security number from the Practice ID grid.
10. If you file mammography claims, select **Mammography Cert** and enter the certificate number to associate with the rule.
11. If you file laboratory claims using a CLIA number, select **CLIA** and enter the CLIA number to associate with the rule.
12. If your carrier requires a care plan oversight number, select **Care Plan Oversight**, enter the care plan oversight number, and select an ID qualifier to associate with the rule.
13. If needed, enter up to three legacy and qualifiers to associate with the rule using the Legacy Identifier 1, 2, and 3 fields. Use these fields to customize your rule to meet filing requirements with an insurance carrier(s).
14. Click **Save**.

Chapter 7 - Referring Provider Records

Many patient visits come to a practice as a result of a referral from another provider. When a patient is referred to your practice, create a record for the referring provider. Add data such as the Unique Physician Identification Number (UPIN), NPI, tax ID, and so on. In this record, you can link the provider to a particular insurance company/category, if needed.

Entering Referring Provider Information

1. On the Lists menu, select **Referring Providers**. The Referring Provider List screen appears.

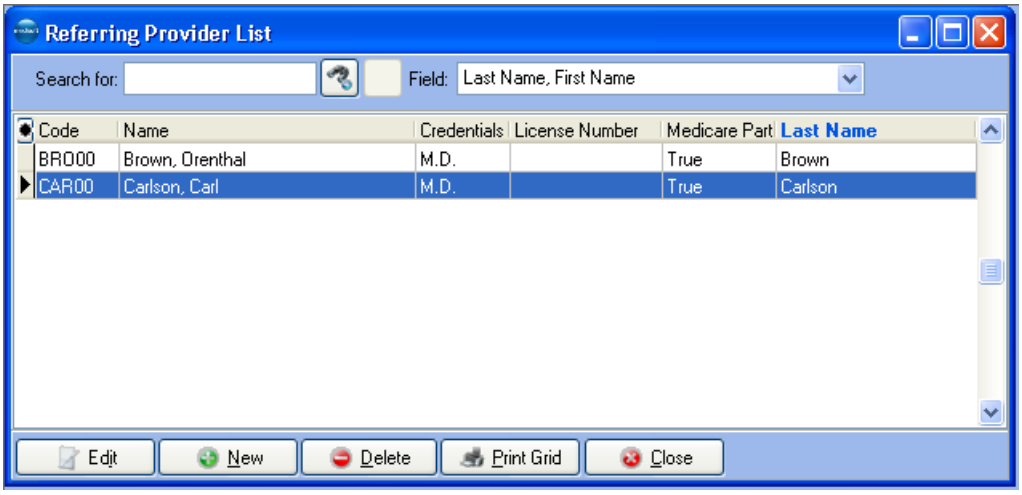

Figure 53. Referring Provider List screen

2. Click **New**.

   --OR--

   Select a record on the Referring Provider List screen and click **Edit**.

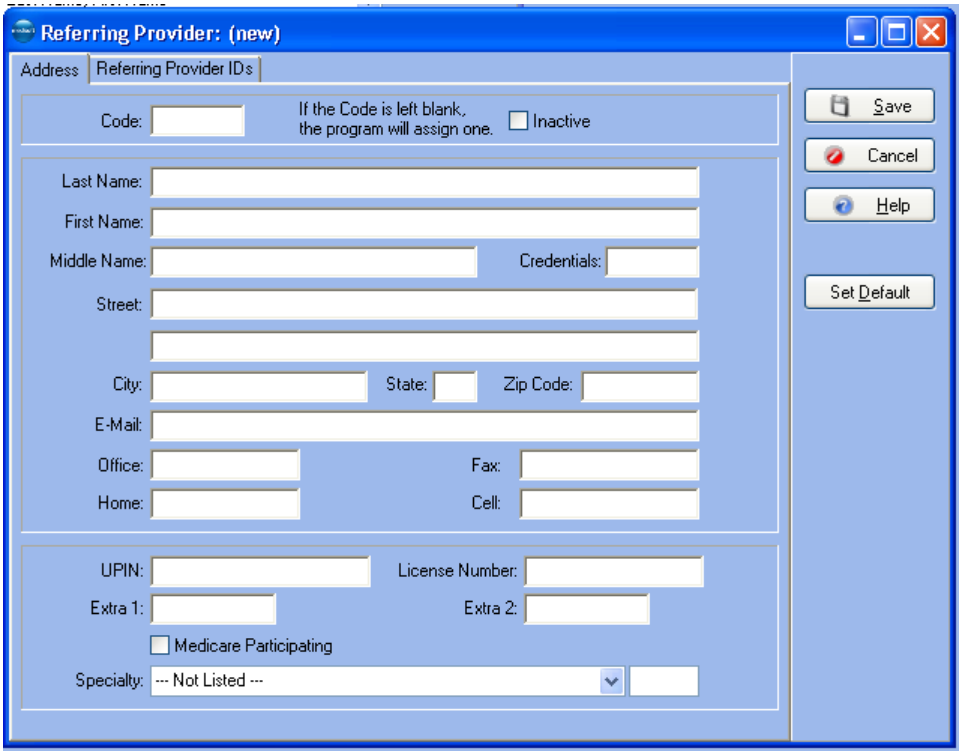

Figure 54. Referring Provider: (new) screen

3. On the Address tab, enter demographic information for the referring provider such as last name, first name, title.

   Also, if you are sending electronic claims, select from the Specialty list the referring provider's special field of practice. If you need to use a specialty code that is different than the usual code, select "Not Listed" and enter your specialty code in the field that appears next to the Specialty list.

NOTE: This field is not used for sending paper claims unless you have modified your claim form to include this information.

Entering Referring Provider Rules

Use the Referring Provider IDs tab and grid to enter or edit key data elements associated with a referring provider (NPI, taxonomy, legacy numbers). You will set up at least one entry (rule) on the Referring Provider IDs grid for each referring provider that works with your practice and associate this information to all insurance carriers or insurance classes or a particular insurance carrier or an insurance class. For more information on creating rules, see “Creating Rules Overview” on page 24.

1. Select the **Referring Provider IDs** tab.

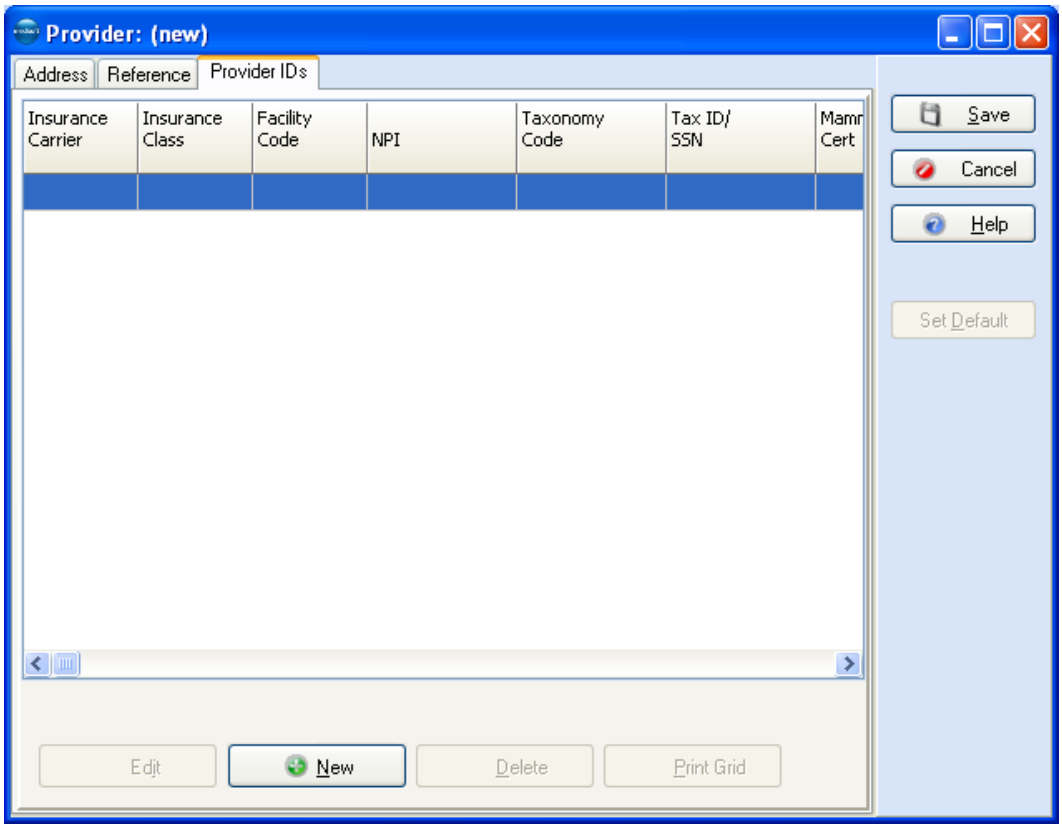

Figure 55. Provider screen, Provider IDs tab

2. Click **New** to create a new grid entry.

   --OR--

   Select an entry on the grid and click **Edit**.

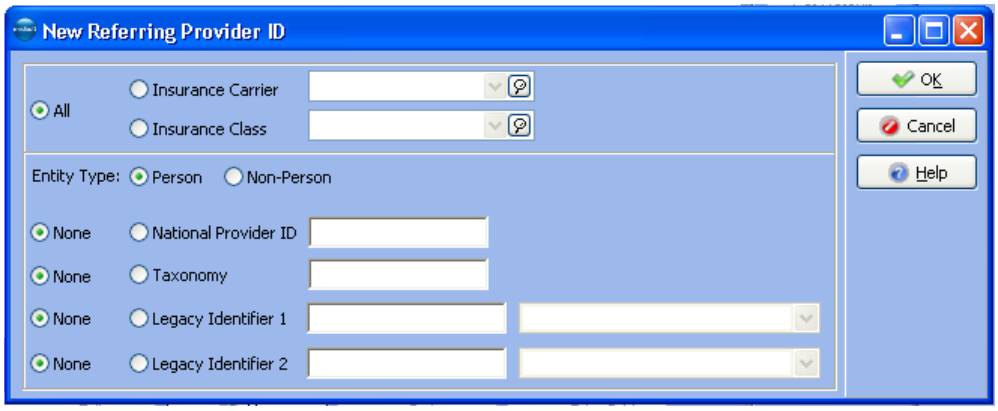

Figure 56. New Referring Provider ID screen

3. Select either **All**, **Insurance Carrier**, or **Insurance Class**.
4. Select either **Entity Type: Person** or **Entity Type: Non-Person**.
5. Select either **None** or **National Provider ID**.
6. Select either **None** or **Taxonomy**.
7. If needed, enter up to two legacy numbers and qualifiers to associate with the rule using the Legacy Identifier 1 and 2 fields. Use these fields to customize your rule to meet filing requirements with an insurance carrier(s).
8. Click **Save**.

Chapter 8 - Insurance Classes and Insurance Carriers

Set up the insurance carrier records completely to ensure that your claims are processed in a timely manner. You can create insurance classes, into which you can group carriers based on a common feature. In addition, create your carrier records.

Insurance Classes

Use this screen to create insurance classes, such as Blue Shield or Medicare. Use these classes to group insurance carriers for easier reporting and payment posting.

To create insurance classes:

1. On the Lists menu, select **Insurance**.
2. Select **Classes** from the drop-down menu. The Insurance Class List screen appears.

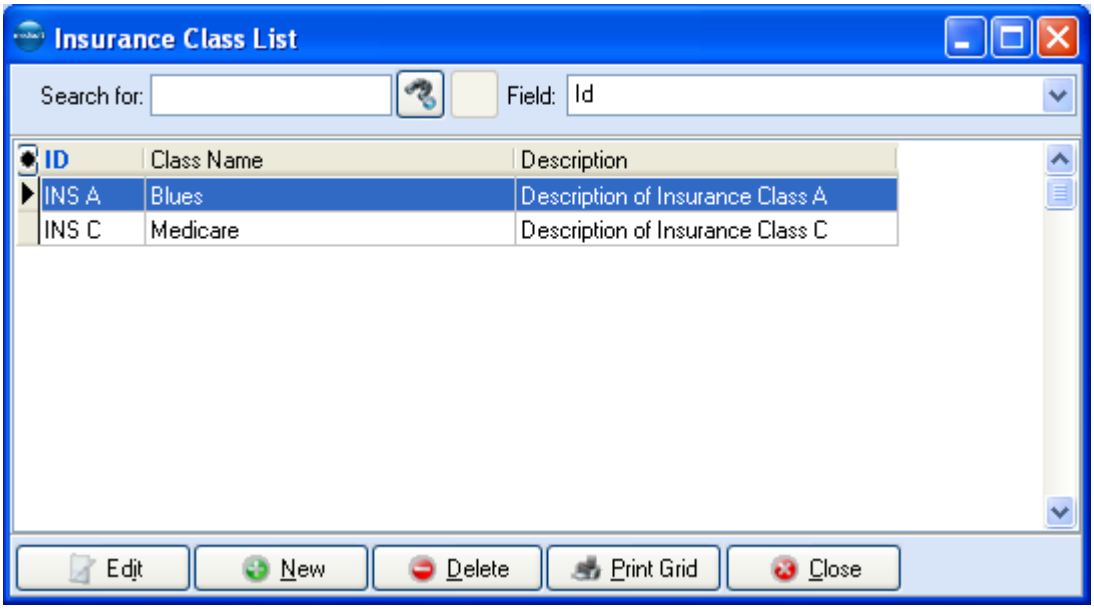

Figure 57. Insurance Class List screen

3. Click **New**.

4. Enter an ID, Name, and Description for the class.

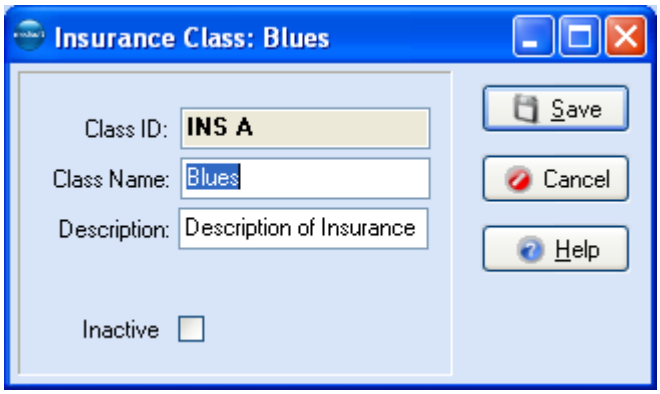

Figure 58. Insurance Class screen

5. Click **Save**.

Insurance Carriers

1. On the Lists menu, select **Insurance**.
2. Select **Carriers**. The Insurance Carrier List screen appears.

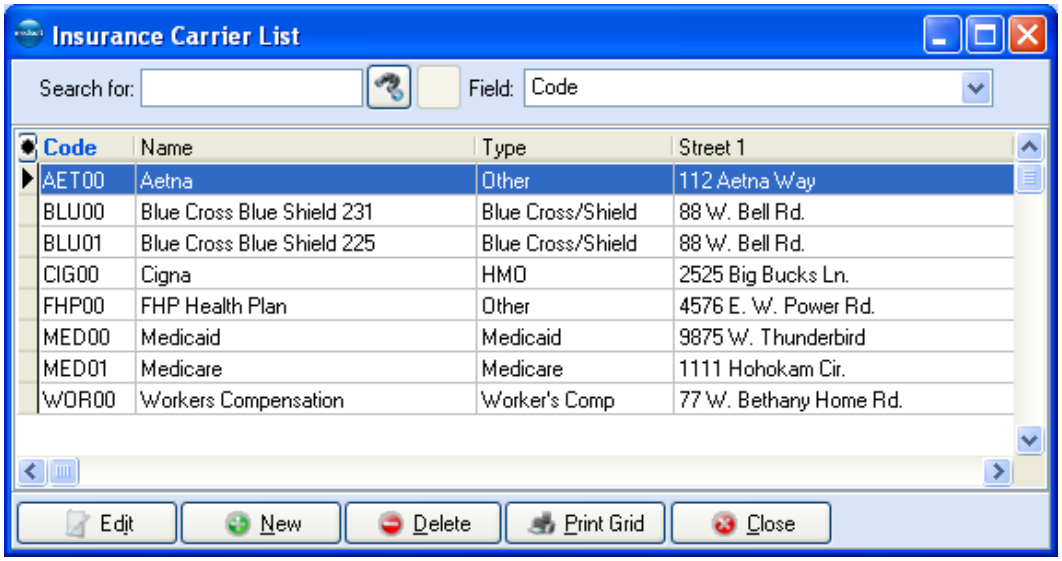

Figure 59. Insurance Carrier List screen

3. Click **New**.

   --OR--

   Select an entry on the Insurance Carrier List and click **Edit**.

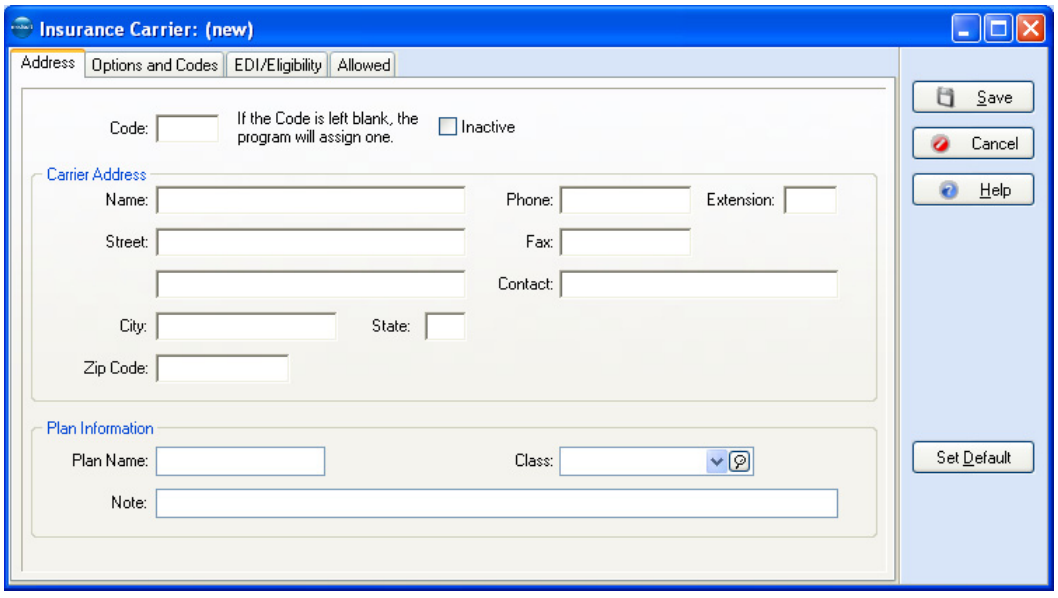

Figure 60. Insurance Carrier screen

4. Enter the carrier's information.
5. From the Class list, select an insurance class to assign to the carrier.
6. Select the Options and Codes tab.

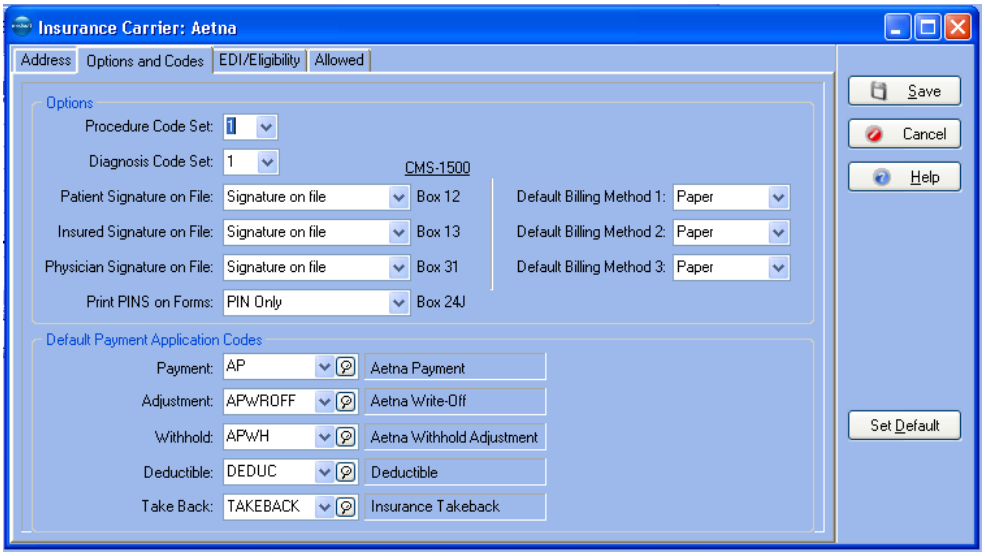

Figure 61. Insurance Carrier screen, Options and Codes tab

7. From the Procedure Code and Diagnosis Code Set lists, select a procedure code set (1, 2, or 3) and a diagnosis code set (1, 2, or 3) to apply to the insurance carrier. Medisoft gives you the ability to assign up to three codes to the same procedure. By using this field, the claims for each carrier can contain the correct code.
8. From the Patient, Insured, or Physician Signature on File lists, for each option select, Leave blank, Signature on file, or Print name.
   These fields control what is printed in the signature Boxes 12, 13, and 31, respectively, on the CMS - 1500 claim form, if you are printing claims. These fields do not control whether anything is printed in these boxes, but what is printed. Whether anything prints is controlled by settings on the Case screen, Policy tab, Accept Assignment and Benefits Assigned field, and Provider screen, Address tab, Signature on File field.
   The Signature on file option prints "Signature on File" (if the Signature on file field has been activated in the patient and provider records).
   The Print name option prints the name of the patient, insured, or physician.
   The Leave blank option prints nothing.
9. From the Print PINs on Forms list select PIN Only or Leave Blank. When setting up Medicare and Medicaid carriers for printed claims, select PIN Only; otherwise, select Leave Blank.
10. From the Default Billing Method 1, 2, and 3 lists, select either Paper or Electronic for handling primary (1), secondary (2), and tertiary (3) claims. Select Paper if claims are to be printed; select Electronic if claims are to be transmitted electronically.
11. In the Default Payment Application Codes box select default payment codes.

12. Select the **EDI/Eligibility** tab. The EDI/Eligibility tab is used for electronic claims.

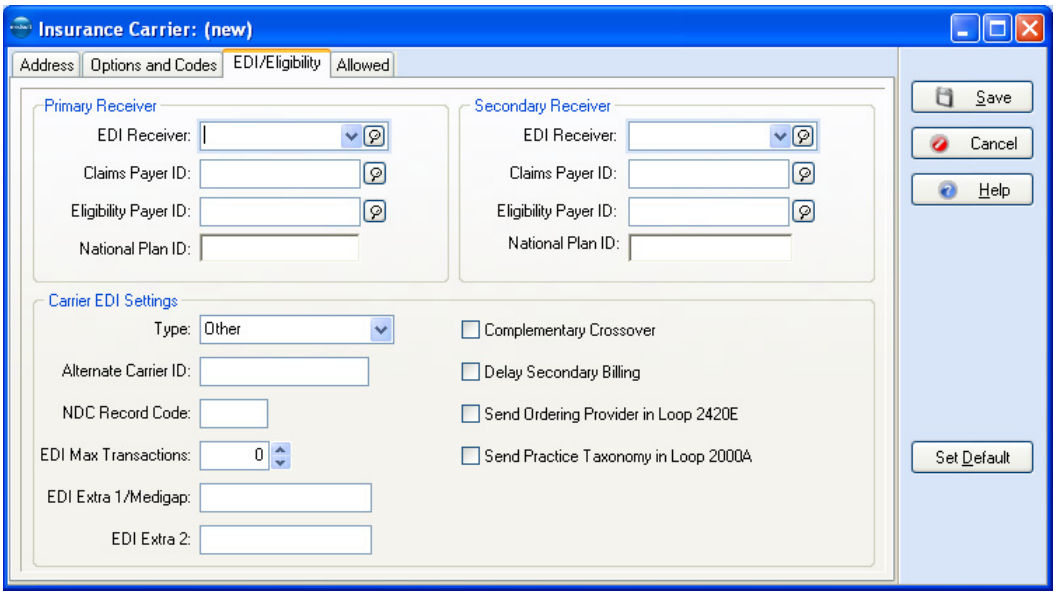

Figure 62. Insurance Carrier screen, EDI/Eligibility tab

13. In the Primary Receiver panel on the EDI Receiver list, select the EDI receiver you use when sending electronic claims for primary insurances. If you do not enter an EDI receiver in the EDI Receiver field, electronic claims will not be created or sent for this insurance company.

14. In the Claims Payer ID field, enter the payer ID for the insurance carrier. Refer to the enrollment information you received from the carrier/clearinghouse and look up the commercial identification number/ submitter identification numbers assigned to the insurance company by the clearinghouse.
    If you use the eligibility verification service and want to verify eligibility with this insurance carrier, in the Eligibility Payer ID field, enter the payer ID (for some carriers, the eligibility payer ID is different from the payer ID). Refer to the enrollment information you received from the clearinghouse and look up the commercial identification number/ submitter identification numbers assigned to the insurance company by the clearinghouse.
    From the Type list select a type for the insurance company.

15. Leave Alternate Carrier ID blank. Revenue Management will populate this field if needed.

16. If needed, select from the EDI Max Transactions list, a maximum number of transactions accepted by the carrier. This field is available for those carriers that limit the number of transactions per claim accepted electronically. If you submit more than the maximum number of transactions per claim, Medisoft automatically splits the claim.

17. If the insurance carrier is used as both a primary EDI insurer and a Medigap insurer, in the EDI Extra 1/Medigap field, enter the Medigap number. The number entered is the COBA Medigap claim-based identifier received from the national Coordination of Benefits Contractor (COBC).

18. The EDI Extra 2 field is used by Revenue Management.

19. Select the Complimentary Crossover check box if you are filing complimentary crossover claims. Secondary insurance will not be sent in the claim file. However, Medisoft will mark the secondary as sent. If you are sending Medigap claims, do not select this box.

20. Select the Delay Secondary Billing check box, if there is a secondary insurance company and you want to delay printing the secondary claim form until a response is recorded from the primary carrier. To print the secondary claim form at the same time the primary is printed, leave the box empty.
21. Select the Send Ordering Provider in Loop 2420E check box to send ordering provider information on an electronic claim.
22. Select the Send Practice Taxonomy in Loop 2000A check box to send taxonomy in Loop 2000A for electronic claims. Loop 2000A is usually used to report taxonomy for individual providers. Contact your carrier for more information on their taxonomy requirements.
23. Select the **Allowed** tab. This displays the amount last paid by the selected carrier for each procedure code available in Medisoft. If you do not enter anything in this table, each time a carrier makes a payment on a particular procedure code, Medisoft takes the amount paid plus any deductible and divides it by the established Service Classification percentage to arrive at the allowed amount.

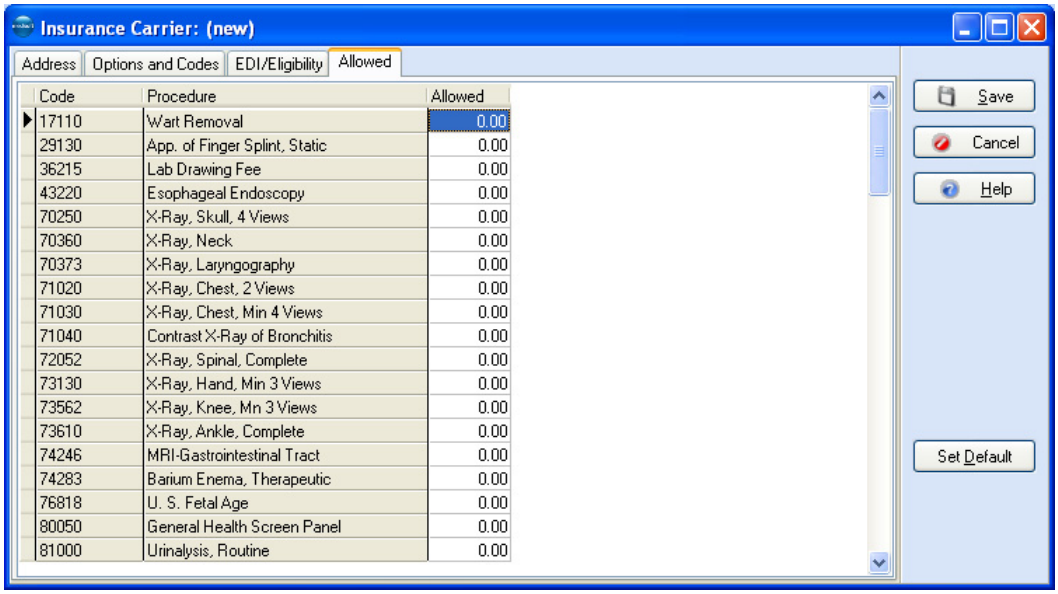

Figure 63. Insurance Carrier screen, Allowed tab

This allowed amount is used when calculating the patient portion estimate of any procedure in the Transaction Entry screen. The existing allowed amount can be changed in the Transaction Entry screen by clicking the Allowed Amt column and entering the corrected amount.

24. Click **Save**.

Chapter 9 - Facility Information

Setup Scenarios

If you have a facility or a lab attached/affiliated with your practice, you will need to create a record for it. There are two components to the record: contact/demographic data entered on the Address tab and billing-specific information entered on the Facility IDs tab.

A facility or lab is a location to which mail might be sent or calls directed, that has a separate address from your practice.

Entering Facility Information

1. Click Lists and select **Facilities**. The Facility List screen appears.

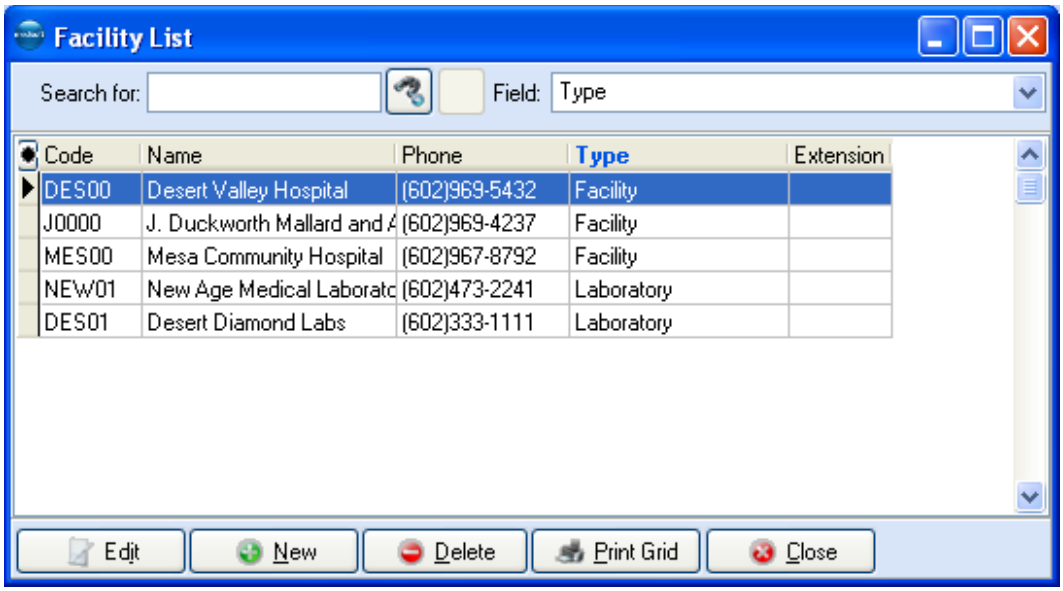

Figure 64. Facility List screen

2. Click **New**.

   --OR--

   Select a record on the Facility List and click **Edit**.

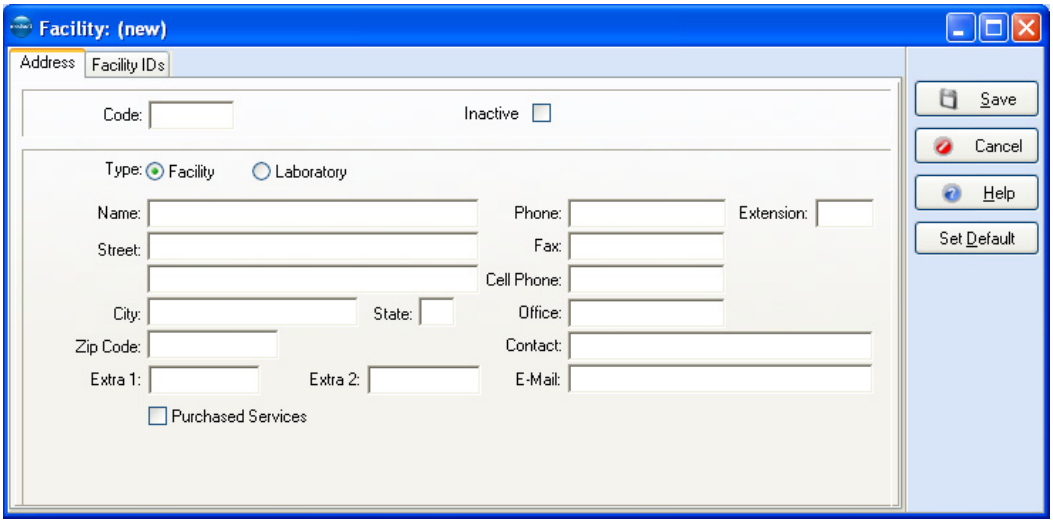

Figure 65. Facility screen, Address tab

3. Enter contact data associated with the facility, including a name, address, telephone number.
4. If the facility is a lab, select the **Laboratory** button; if the facility is not, select **Facility**.

Entering Facility IDs Rules

Use the Facility IDs tab to enter or edit key data specific to the facility (NPI number, taxonomy number, CLIA number, legacy numbers). If your practice is associated with a facility or a lab, set up at least one rule on the Facility IDs screen and associate this information to a specific insurance carrier or an insurance class.

If you have entered a separate NPI number for your facility and need to send facility billing information for box 32 of the CMS 1500 form, specify the type of facility and qualifier along with the facility NPI number. If you need to send it on claims, select the Send Facility on Claim check box.

For more information on creating rules, see “Creating Rules Overview” on page 24.

1. Select the **Facility IDs** tab. The Facility screen appears.

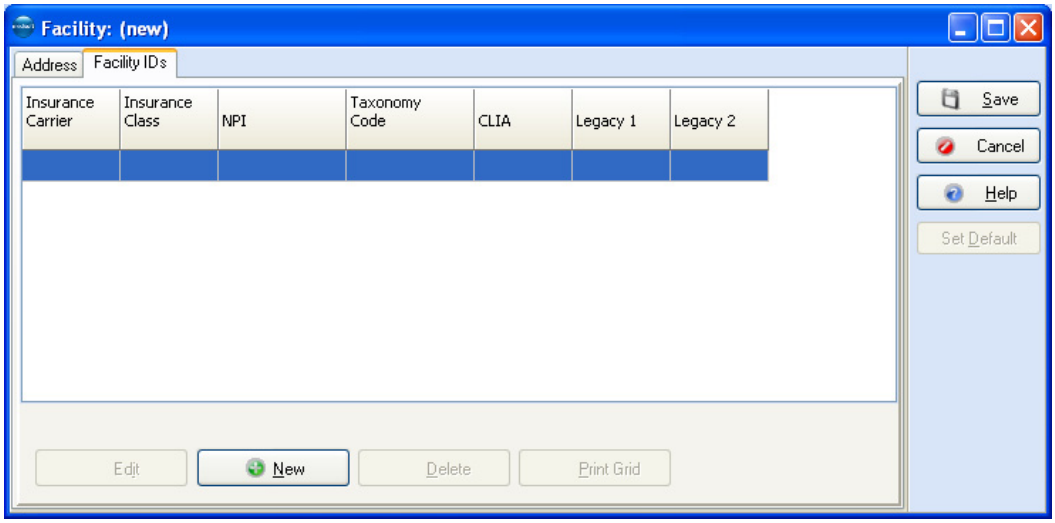

Figure 66. Facility screen

2. Click the **New** button to create a new rule.

   --OR--

   Select the record on the grid and click **Edit**.

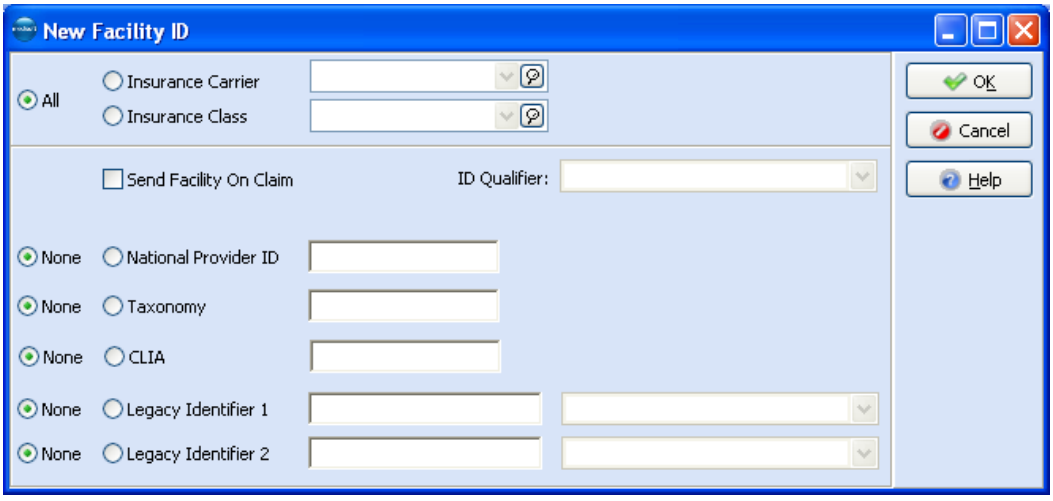

Figure 67. New Facility ID screen

3. Select either **All**, **Insurance Carrier**, or **Insurance Class**.

   To apply the rule to a specific insurance carrier, select the **Insurance Carrier** button and click the magnifying glass to select the insurance carrier.

   To apply the rule to a specific insurance class, select **Insurance Class** and click the magnifying glass to select the insurance class.

4. To include facility information on a print or electronic claim, select the **Send Facility on Claim** box and select an ID Qualifier.
5. Select either **None** or **National Provider ID**. Select **National Provider ID** and enter an NPI number to associate the facility NPI number with the rule.
6. Select either **None** or **Taxonomy**.
7. Select either **None** or **CLIA**.
8. If needed, enter up to two legacy numbers and qualifiers to associate with the rule using the Legacy Identifier 1 and 2 fields. Use these fields to customize your rule to meet filing requirements with an insurance carrier(s).
9. Click **Save**.

Chapter 10 - Attorney, Employer, or Other Addresses

The Address file is your address book in Medisoft. It keeps the names, addresses, and phone numbers of important outside contacts, such as attorneys, employers, referral sources, and so on.

The Address file will include all important contact persons whose phone, fax, cell, and e-mail numbers the practice needs.

The addresses maintained in Medisoft are classified by “type” assigned to help you select them in a drop-down list. These types include: Attorney, Employer, Miscellaneous, and Referral Source.

To set up address records:

1. On the Lists menu, select **Addresses**. The Address List screen appears.

Figure 68. Address List screen

2. Click **New** on the Address List screen. The Address screen appears.

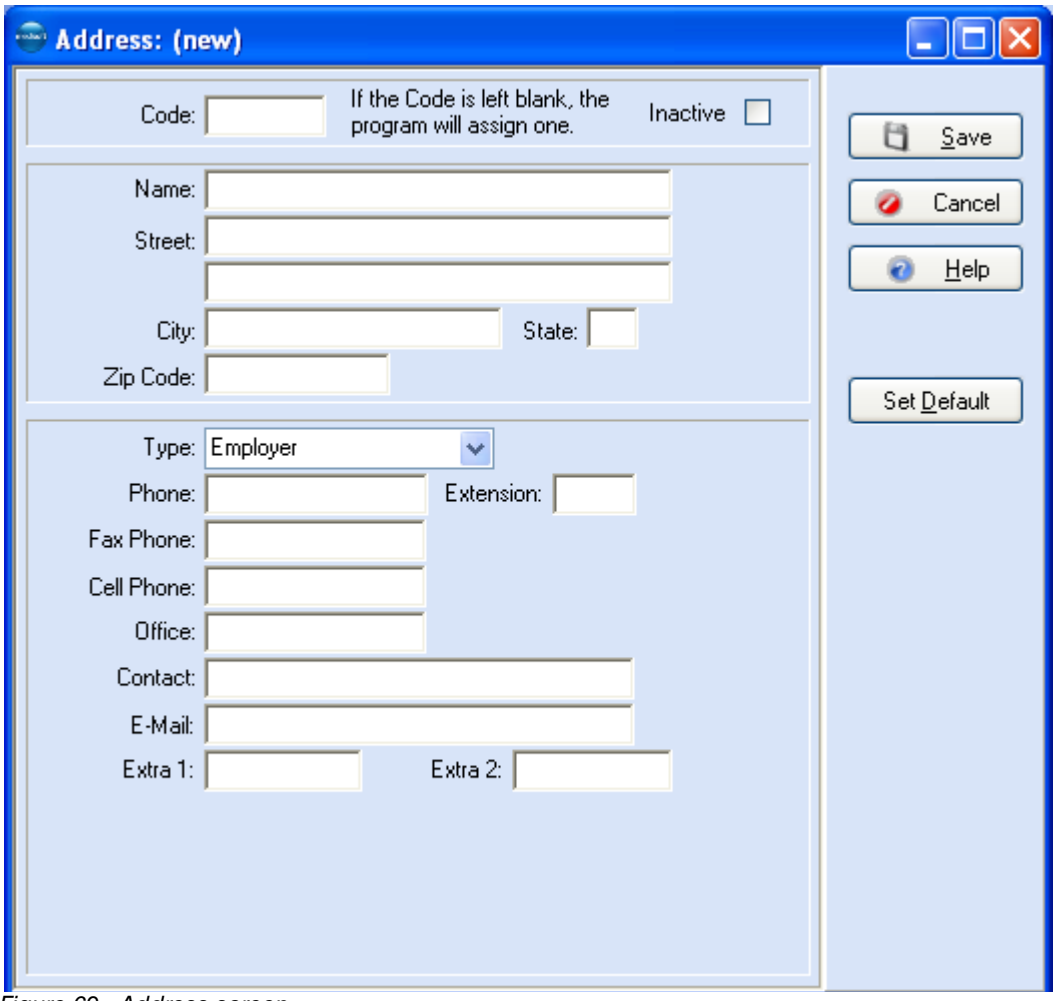

Figure 69. Address screen

3. Enter a Code for a new address record or leave the field blank and let Medisoft create a unique code.
4. Enter demographic data for the address.
5. From the Type list, select **Attorney**, **Employer**, **Miscellaneous**, or **Referral Source**.
6. Enter other demographic data such as phone numbers and email address.
7. Click **Save**.

Chapter 11 - Procedure, Payment, and Adjustment Codes and Diagnosis Codes

In this chapter you will learn about entering procedure and diagnosis codes that are used when you enter charges for your patients.

Procedure, Payment, and Adjustment Codes

Procedure codes are used to communicate procedure information between patient, provider, and third-party payers.

The Procedure/Payment/Adjustment List screen shows what codes have been set up.

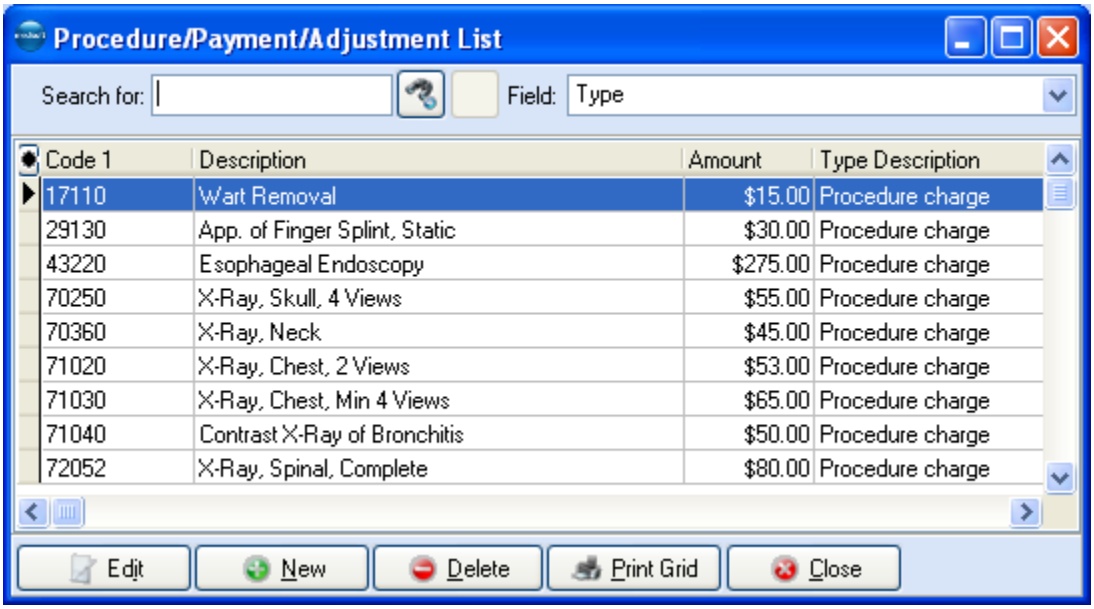

Figure 70. Procedure/Payment/Adjustment List screen

At the top of the screen, there are two fields to help you find a procedure code: Search for and Field. Field defaults to Type but you can change it to Code 1 or Description. If you are not sure of the complete code, description, or type, enter the first few letters or numbers in the Search for field. As you type, the list automatically filters to display records that match.

General Tab

Enter a new code number, description, and type in the General tab.

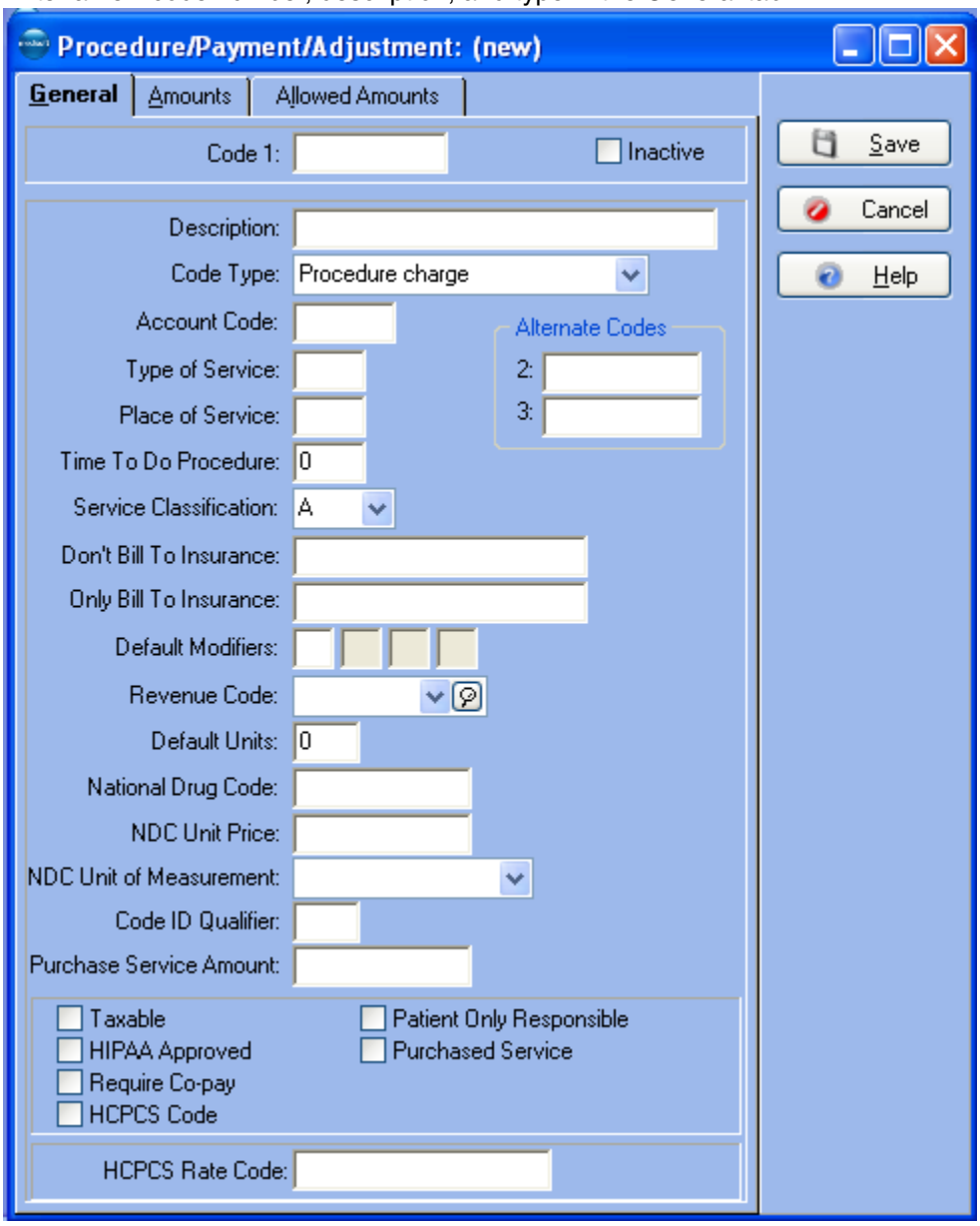

Figure 71. Procedure/Payment/Adjustment screen

Amounts Tab

The Amounts tab links to the Price Code field on the Account tab of the Case screen. Medisoft Advanced and Medisoft Network Professional allow 26 charge amounts for each code entered in

Medisoft. The applicable charge amount is selected in the Account tab of each patient's Case screen.

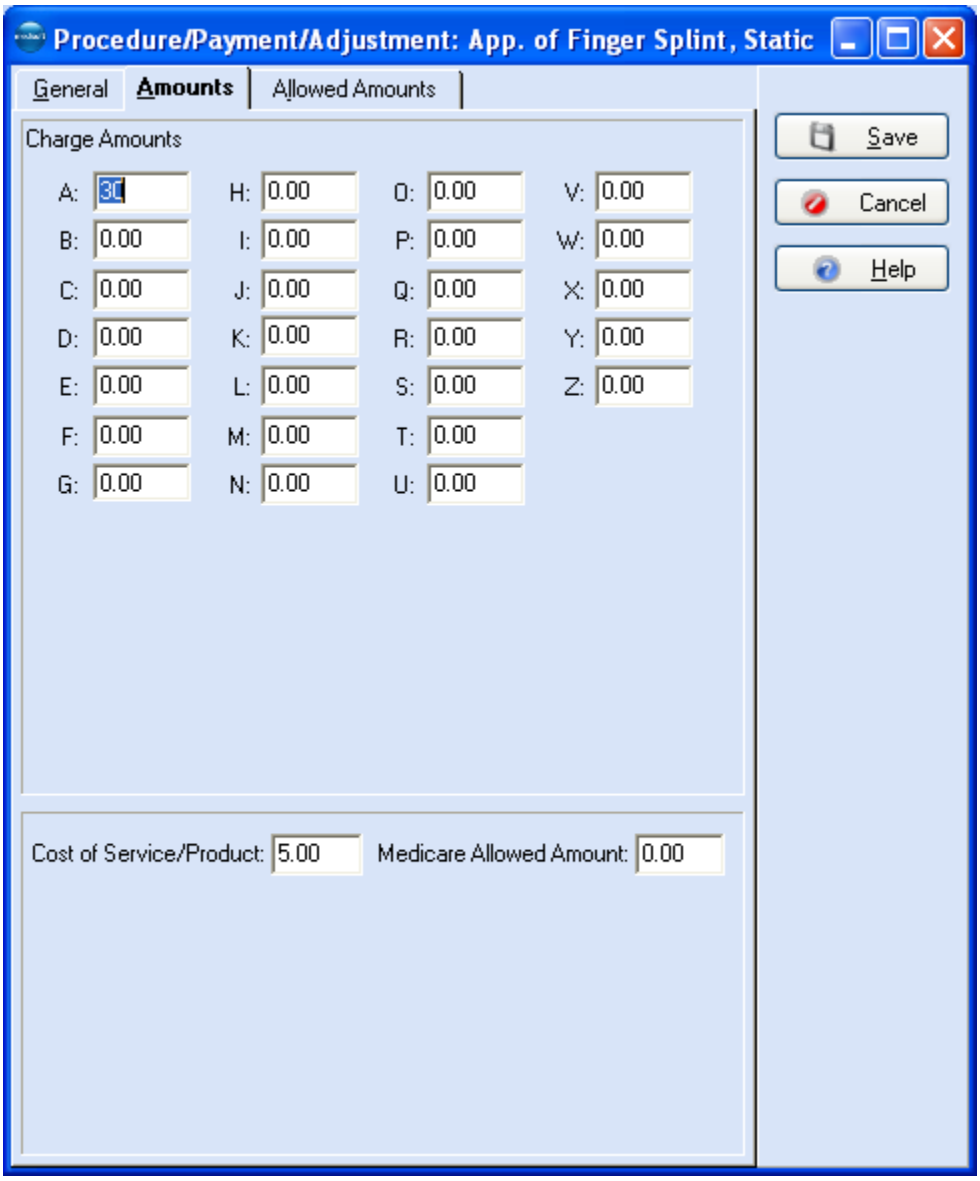

Figure 72. Procedure/Payment/Adjustment screen, Amounts tab

Allowed Amounts Tab (Advanced and Medisoft Network Professional)

The Allowed Amounts tab keeps track of how much each insurance carrier pays for a particular procedure. Medisoft calculates the allowed amount based on the amount paid, any applicable

deductible, and the service classification. This amount is used in calculating the patient portion of any transaction entered in Transaction Entry.

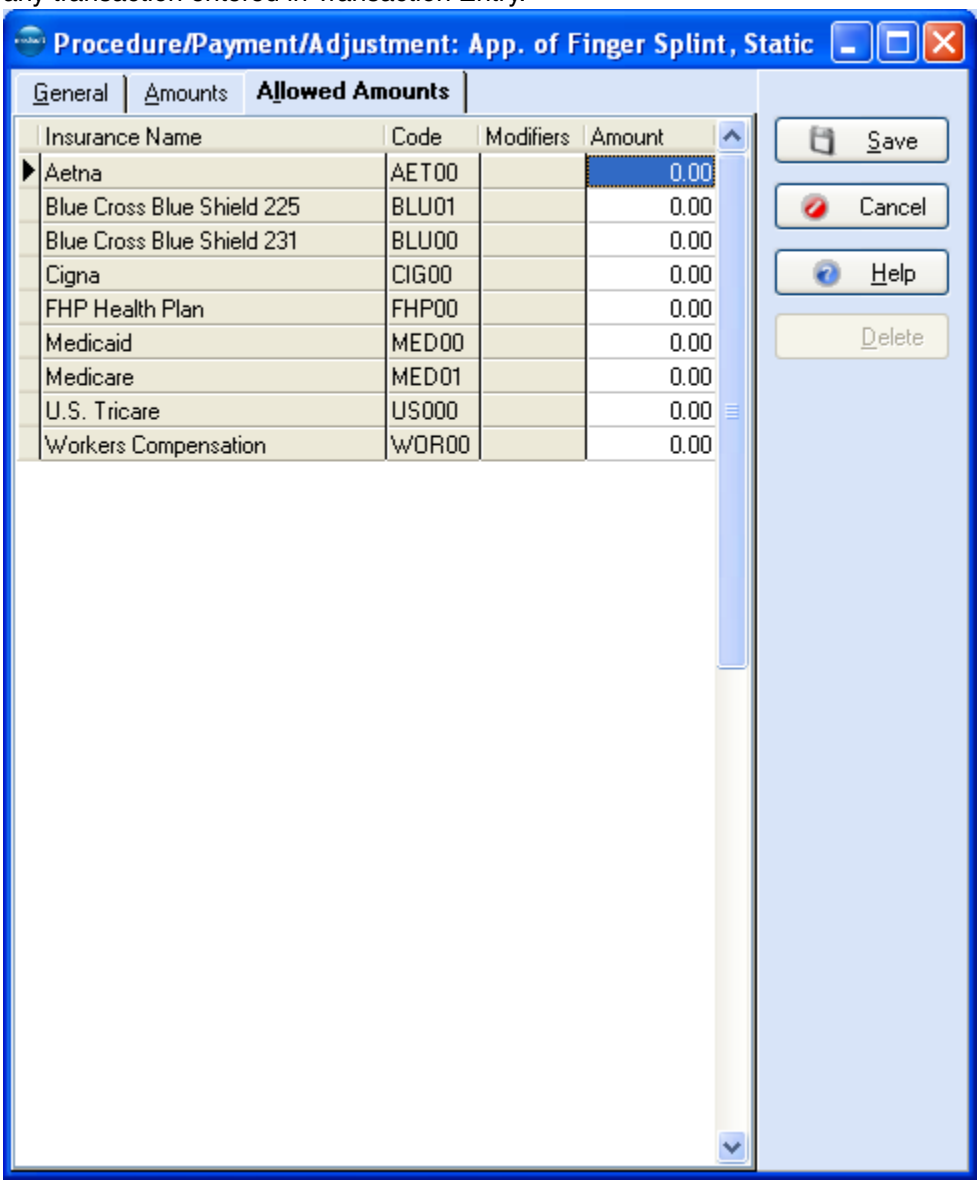

Figure 73. Procedure/Payment/Adjustments screen, Allowed Amounts tab

MultiLink Codes

MultiLink Codes are groups of procedure codes combined under one access code. They are for procedures that are normally performed at the same time, for example, for a physical exam or a routine set of treatments.

There are two advantages to using MultiLinks:

- You reduce data entry time by creating several transactions at once with a single code.
- You reduce omission errors since you've already included all applicable codes in your MultiLink code.

To create MultiLink codes:

1. On the Lists menu, select **MultiLink Codes**. The MultiLink List screen appears.

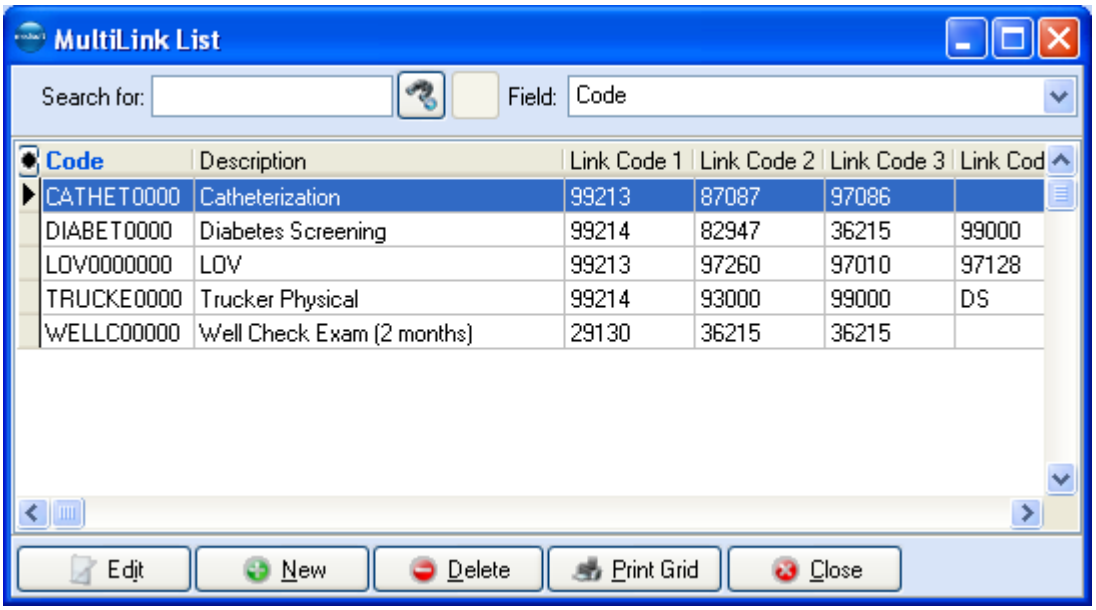

Figure 74. MultiLink List screen

2. Click **New**. The MultiLink Code screen appears.

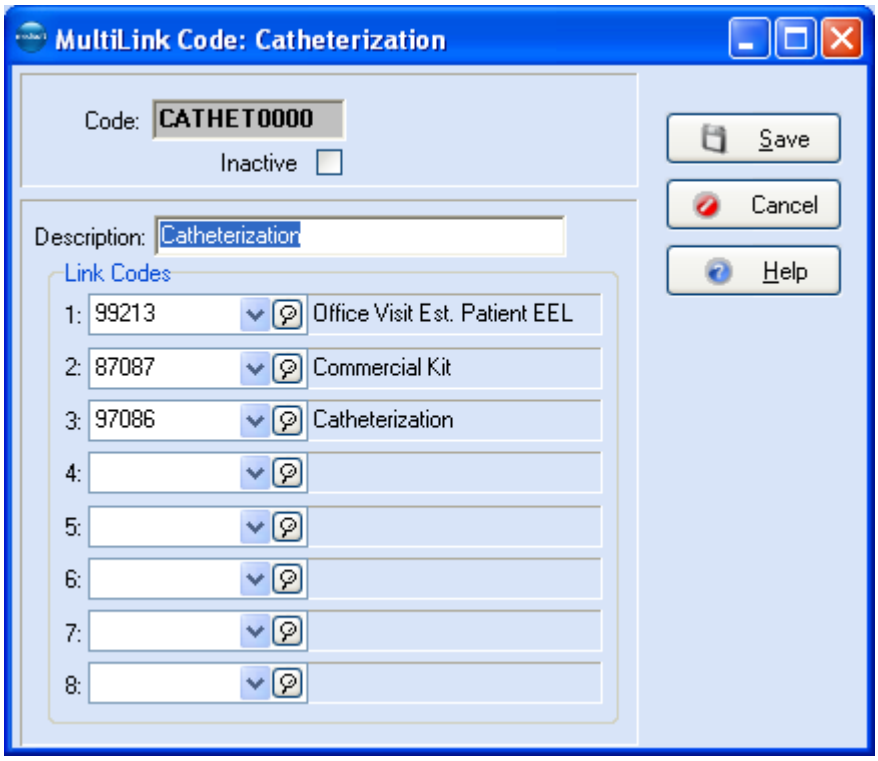

Figure 75. MultiLink Code screen

3. Enter a Code and Description for the procedure.
4. Select the procedures for this code from the Link Code fields.
5. Click **Save**.

Diagnosis Codes

Diagnosis codes describe the medical reason(s) a service is provided. The procedure code tells what the physician did and the diagnosis code tells what the physician found.

To create a new diagnosis code:

1. On the Lists menu, select **Diagnosis Codes**. The Diagnosis List screen appears.

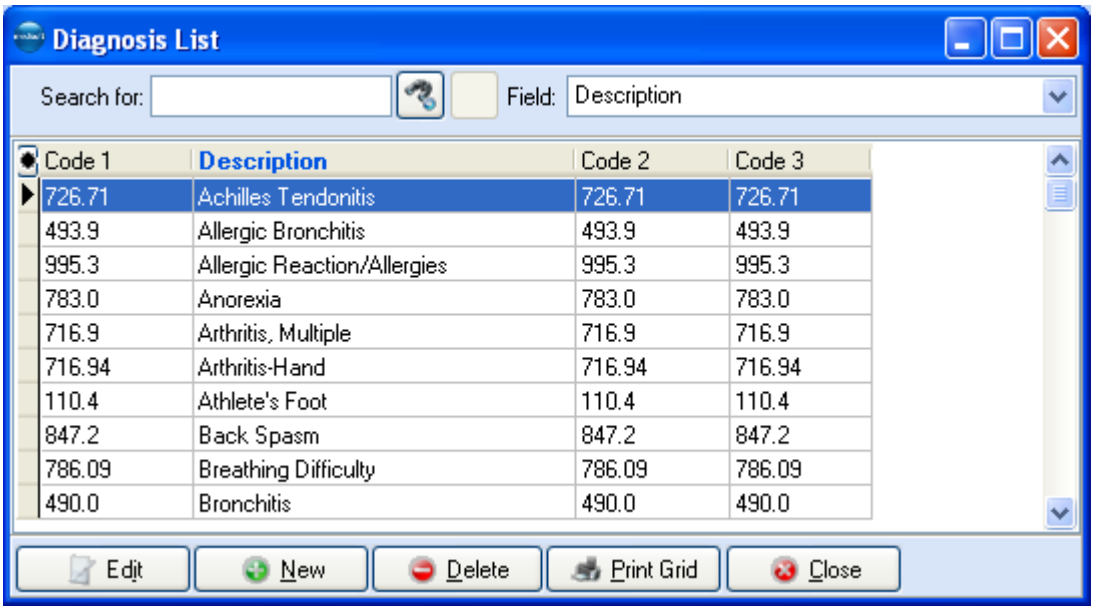

Figure 76. Diagnosis List screen

2. Click **New**. The Diagnosis screen appears.

Figure 77. Diagnosis screen

3. Enter the correct Code and a Description.
4. If necessary, enter Alternate Code Sets. You can use these for entering codes for different carriers but for the same diagnosis.
5. Click **Save**.

Chapter 12 - Billing Code List

A billing code is a user-defined two-character alphanumeric code used in sorting and grouping patient records for billing purposes. A billing code range is a filter available in most reports printed in Medisoft as well.

To enter a billing code:

1. On the Lists menu, select **Billing Codes**. The Billing Code List screen appears.

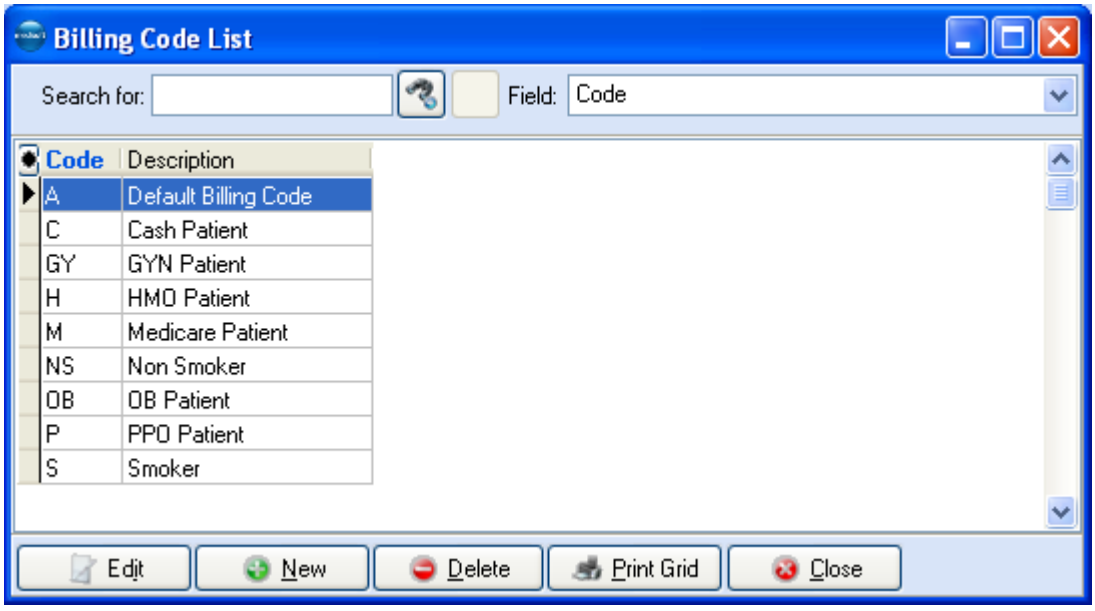

Figure 78. Billing Code List screen

2. Click **New**. The Billing Code screen appears.

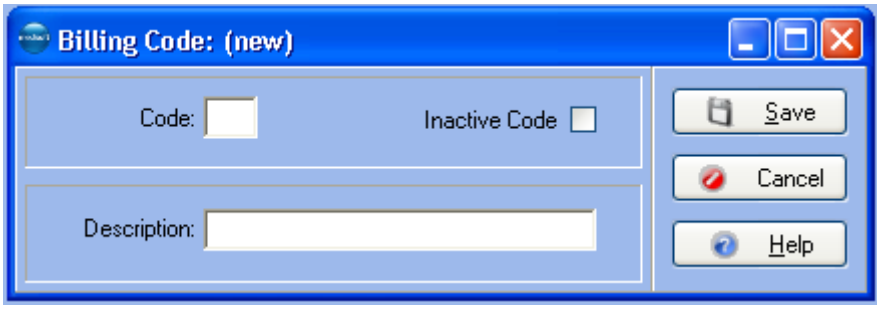

Figure 79. Billing Code screen

3. Enter a Code and Description.
4. Click **Save**.

Chapter 13 - Contact List

NOTE: This is a Medisoft Advanced and Medisoft Network Professional feature.

The Contact List is available to track people with whom you have had contact during the course of business. On the Contact screen, you can add notes regarding your conversations with the contact to help you keep track of what was discussed and any conclusions or information shared during the conversation.

To add a contact

1. On the Lists menu, select **Contact List**.The Contact List screen appears.

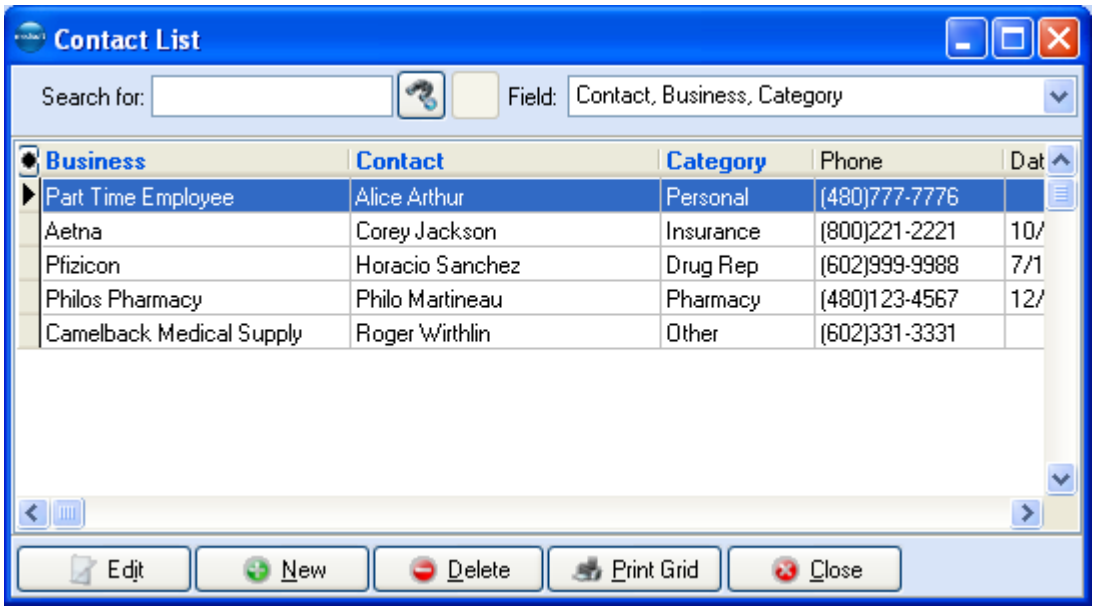

Figure 80. Contact List screen

2. Click **New**. The Contact screen appears.

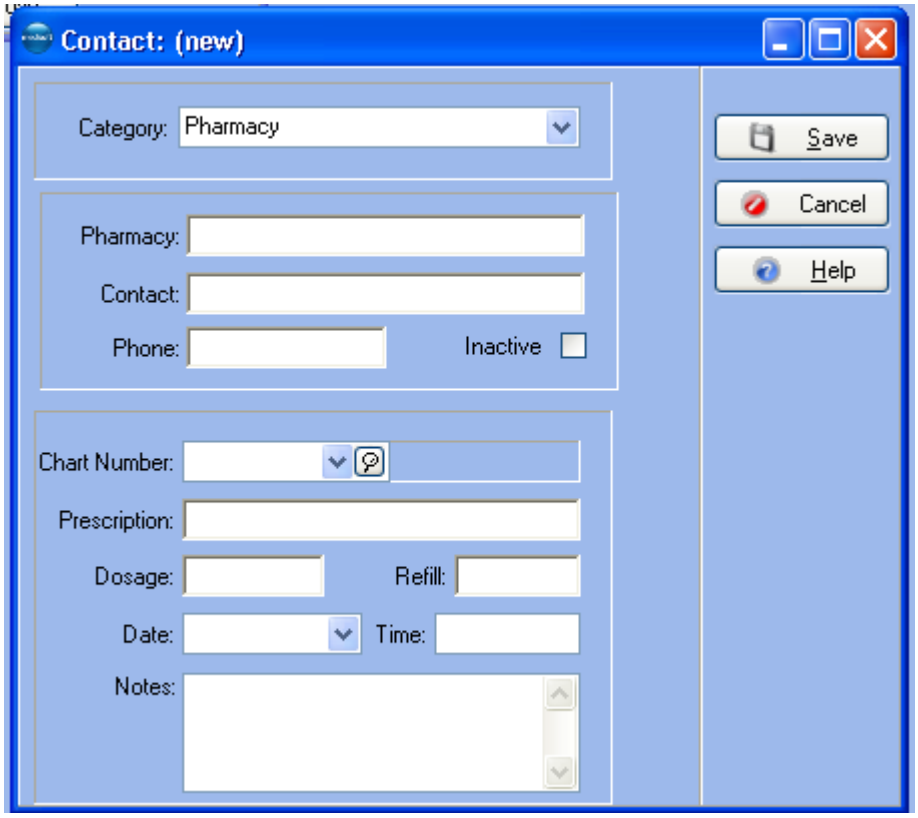

Figure 81. Contact screen

3. Select the Category for the new contact.
4. Enter information as necessary to complete your record.
5. Click **Save**.

Chapter 14 - Patients

One of the most important functions in getting your practice set up is entering patient data. Complete patient information is important for filing claims and processing statements to bill your patients.

Chart Number Considerations

Every patient or guarantor must have a chart number and be set up in the database before you can enter transactions for the patient. You can choose to allow Medisoft to create your patients' chart numbers as you enter their records or you can use your own system.

- If you want Medisoft to create your chart numbers, simply leave that field blank when you create a patient record.
- If you want to use your own system, complete the Chart field as you enter the new patient's information.

If you want to use numeric chart numbers only, open Program Options, select the Data Entry tab, and select the Use numeric chart numbers check box.

There is no need for corresponding numbers within a family; the number sequence has little bearing on grouping of patients. Each patient is set up individually in Medisoft and individual bills are prepared for each guarantor.

Once assigned, the Chart Number cannot be changed. To correct a wrong chart number, you must delete the entire patient record and create a new one with the proper chart number.

All other data in the patient record can be modified.

Entering Patient Information

1. On the Lists menu, select **Patients/Guarantors and Cases**. The Patient List screen appears.

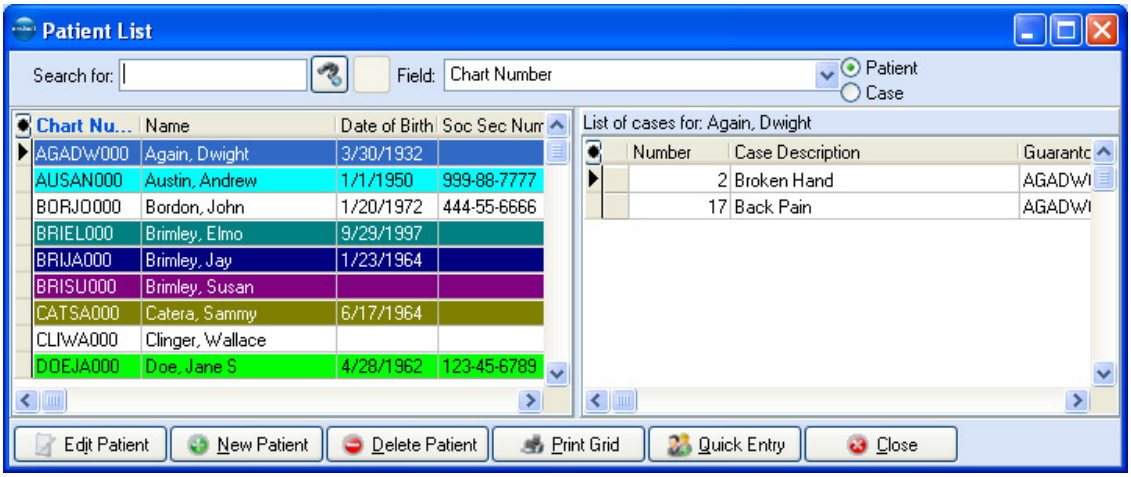

Figure 82. Patient List screen

2. Click **New Patient**. The Patient/Guarantor screen appears.

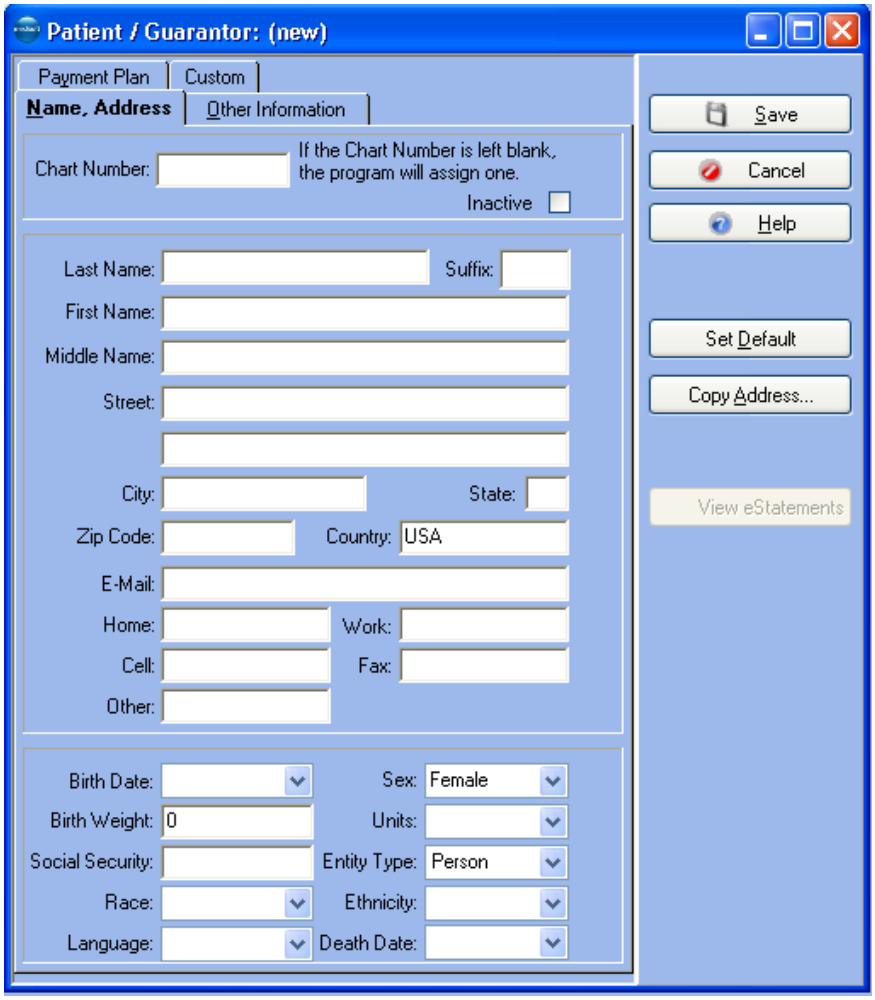

Figure 83. Patient/Guarantor screen

3. On the Name, Address tab, enter all known or necessary information.

Tip: In Medisoft Advanced and Medisoft Network Professional, you can establish default information, applied to all new patient records. Enter the information that is the same for all of your patients, and then click Set Default. To remove your new default settings, hold down CTRL and the button name changes to Remove Default.

When you enter a Social Security number, Medisoft checks through the patient records for any duplications. If a number you enter is a duplicate, Medisoft displays the name and chart number of the patient having that Social Security Number.

4. Select the Other Information tab.

5. Complete the fields here.

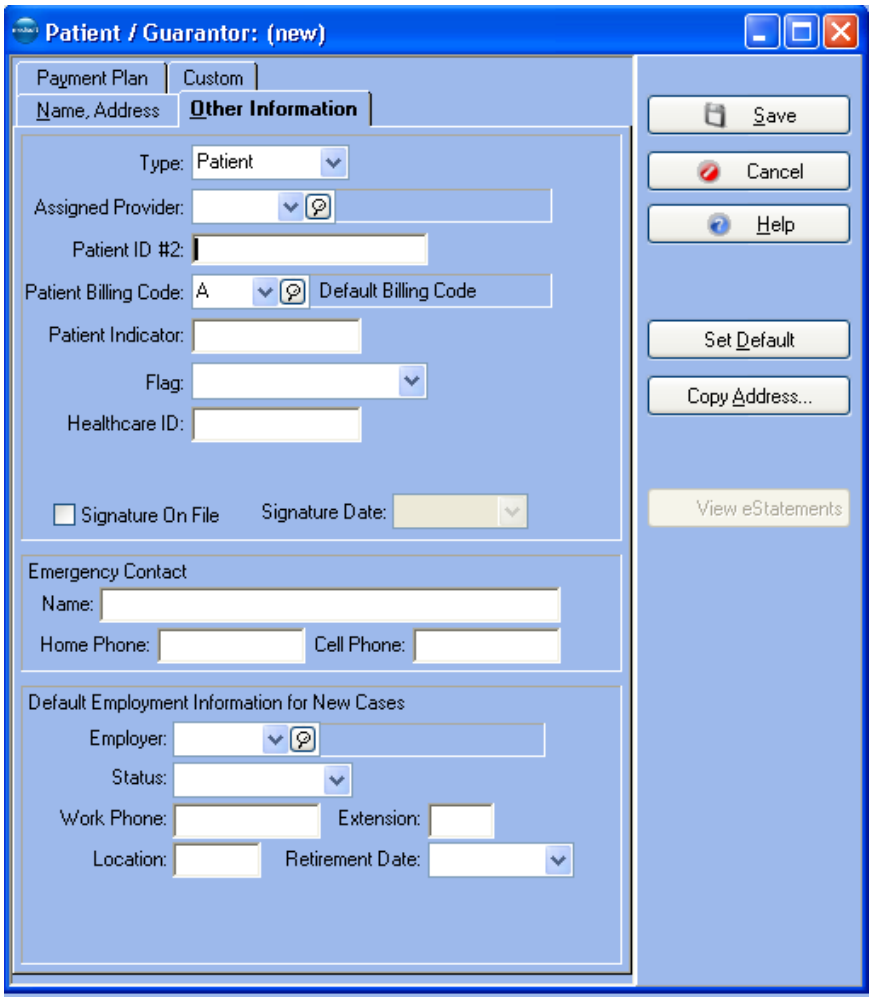

Figure 84. Patient/Guarantor screen, Other Information tab

If the patient's employer record has been set up in the Address file (see "Attorney, Employer, or Other Addresses " on page 67), select it on the Employer field.

If you want to create a new address record, place the cursor in the Employer field and press F8. The Addresses screen will appear.

6. Select the **Payment Plan** tab. Select a Payment Code to set up the payment terms for the patient.

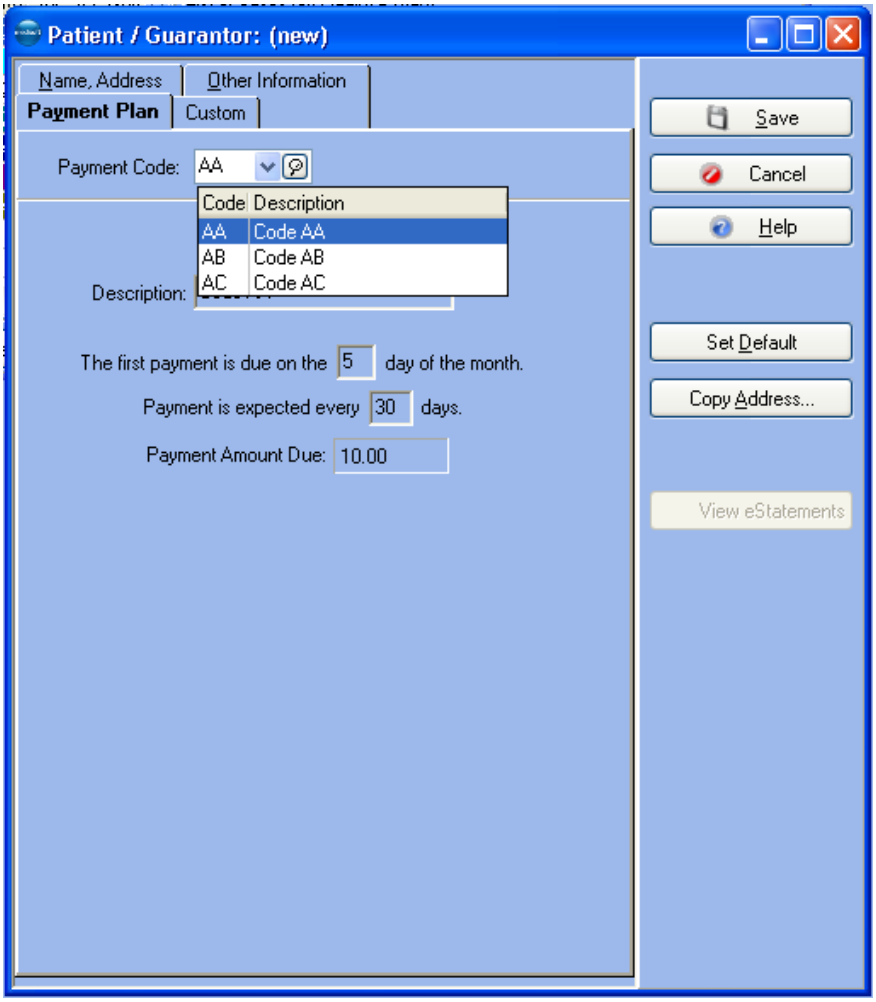

Figure 85. Patient/Guarantor screen, Payment Plan tab

Chapter 15 - Cases

Transactions in Medisoft are generally case-based. A case is a grouping of procedures or transactions generally sharing a common treatment, facility, or insurance carrier. You can set up as many new cases as needed for your patients, depending on changes to their insurance, treatment, diagnosis, and so on. For instance, you are treating a diabetic patient regularly and he is injured on the job. His visits regarding the work-related injury should be kept in a Workers' Compensation case, totally separate from regular visits, for legal and reporting reasons. Ideally, you would have a case for each different malady from which the patient suffers. Then, you can pull up groupings of case visits to help you evaluate the patient's overall health status. By pulling a case that contains all diabetic treatments, one for high blood pressure, one for angina, and one for cancer, you get a better picture of the full range of health problems.

TIP: If a patient comes for a one-time treatment, you can create a transaction for that treatment without creating an entirely new case. Just select different diagnosis codes in Transaction Entry when creating the transaction.

Creating a Case

To create a new case for a patient:

1. On the Lists menu, select **Patients/Guarantors and Cases.** The Patient List screen appears.
2. In the top right of the screen, select **Case**. The buttons on the Patient screen change.

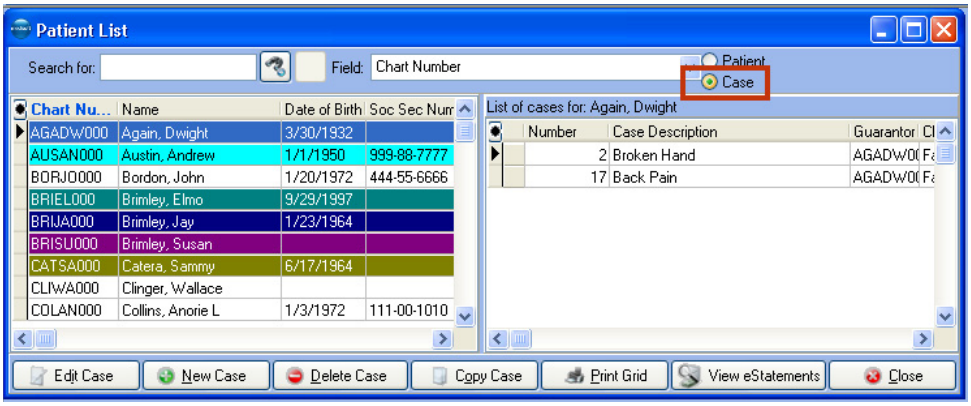

Figure 86. Patient screen with Case selected

3. Click **New Case**. The Case screen appears.

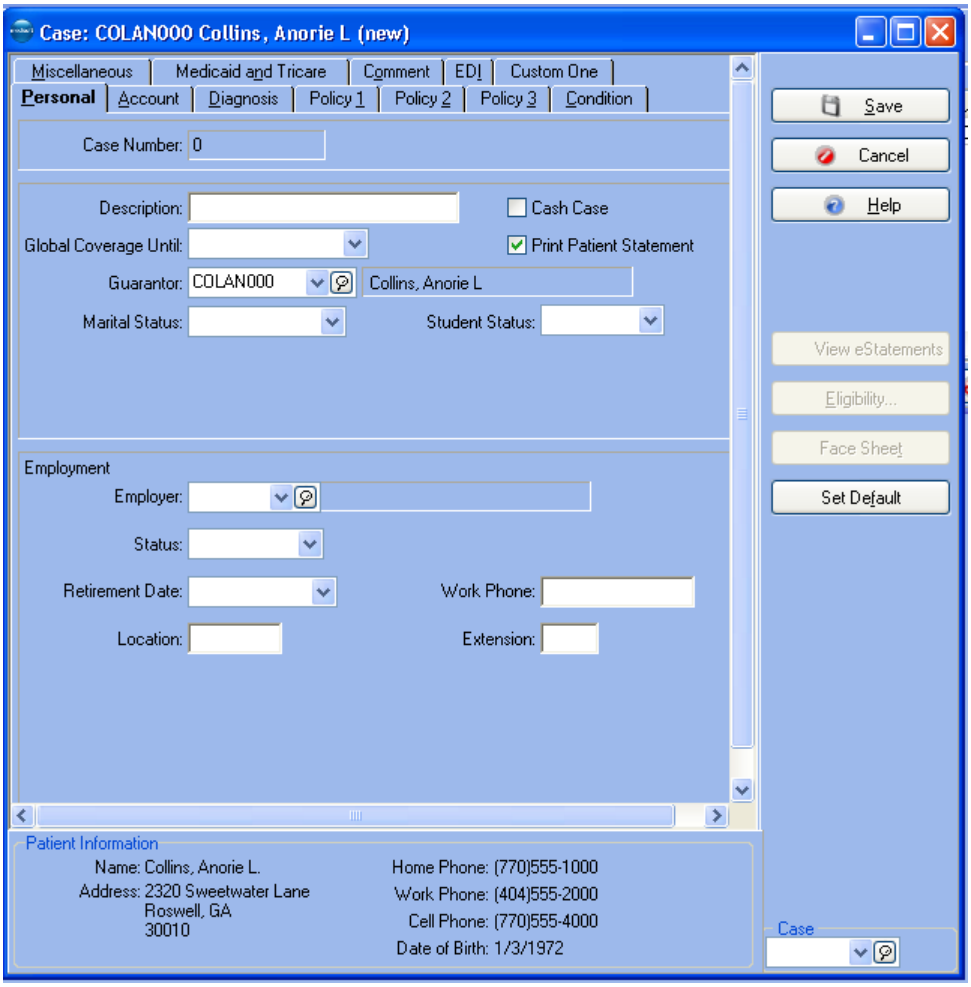

Figure 87. Case screen, Personal tab

Medisoft will pull information from the patient's record into the case record automatically.

4. Complete the fields on each tab as is applicable for the new case. Be as complete as you can, since much of this information will be sent when you file claims.

Tab	Description
Personal	Enter general information on the new case and employer information.
Account	Enter the provider, referral, and attorney information set up in the Address file. Also enter billing and price codes and information on visit authorization, including the number of visits.
Diagnosis	Enter diagnosis codes for this case.
Condition	Enter information pertinent to the illness, pregnancy, or injury, and tracking of symptoms. Also enter dates relative to the condition, plus Workers' Compensation information.

Tab	Description
Miscellaneous	Enter supplemental information such as lab work charges, whether the lab is in-house or outside, Referral and Prescription Dates, Local Use A and Local Use B fields, case Indicator code, and prior authorization.
Policy 1, 2, 3	Enter up to three insurance carriers for the patient, including policy and group numbers, and Insurance Coverage Percents by Service Classification (how much the carrier pays for certain types of procedures). The service percentage classification is tied to each procedure code. A Deductible Met check box is provided in the Policy 1 tab. When the patient meets his or her deductible obligation for the year, select this check box and the status is displayed in the patient account detail of the Transaction Entry screen. The three tabs have the same layout, except Policy 1 has fields for Capitated Plan and Co-Pay Amount and has the Deductible Met check box; Policy 2 has a field for Crossover Plan; and Policy 3 can be set up for tertiary or third-party involvement.
Medicaid and TRICARE	Enter all submission numbers, reference, and data for each carrier. Also, enter branch of service information. Within the Medicaid and Tricare tab are EPSDT and Family Planning indicators, required submission numbers, and reference data for the case. It also includes service information for TRICARE claims.
Multimedia tab (Network Professional only	Add bitmaps to your patient records.
Comment (Advanced and Medisoft Network Professional)	Enter notes to be printed on statements.
EDI	Enter information for electronic claims specific to this case.

5. Click **Save**.

Copying a Case

In Medisoft, you can copy an entire case to help save you time. To do so

1. On the Lists menu, select **Patient/Guarantor and Case**. The Patient List screen appears.
2. Highlight the patient whose case you want to copy. The existing cases for that patient appear in the right pane of the Patient screen.
3. Highlight the case you want to copy.

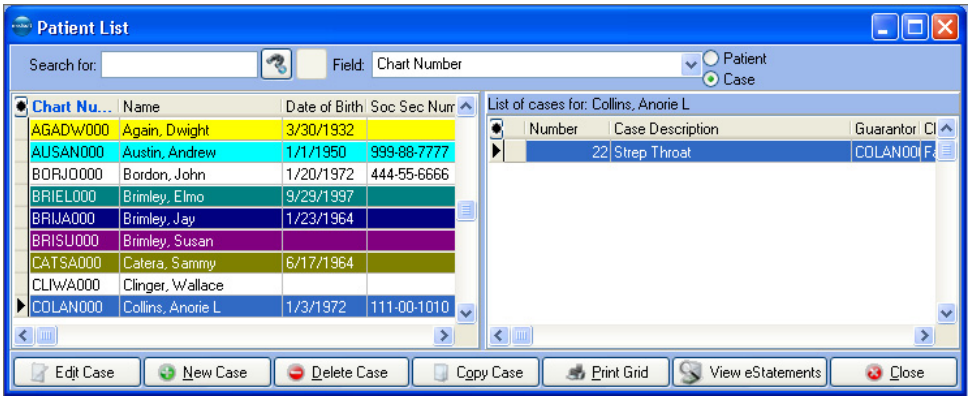

Figure 88. Patient List screen with case selected

4. Click **Copy Case**.

5. The Case screen appears with the data copied.

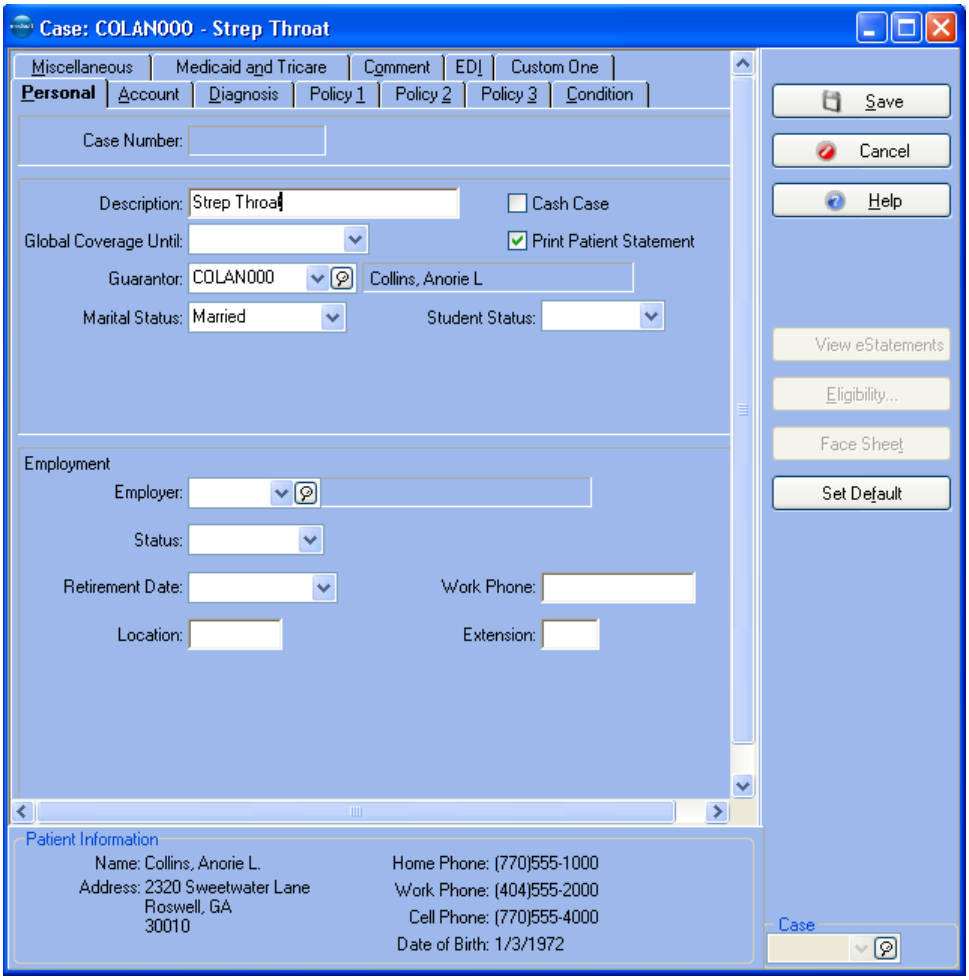

Figure 89. Case screen

6. Modify the case data for the new case.
7. Click **Save**.

Customizing the Case screen

In Medisoft Advanced and Medisoft Network Professional, you can customize the display of the tabs. If you do not need a tab, you can hide it.

To do so,

1. With the Case screen open, right-click on any tab header. A list of the tabs appears. A check mark appears next to the tabs that are currently displayed .

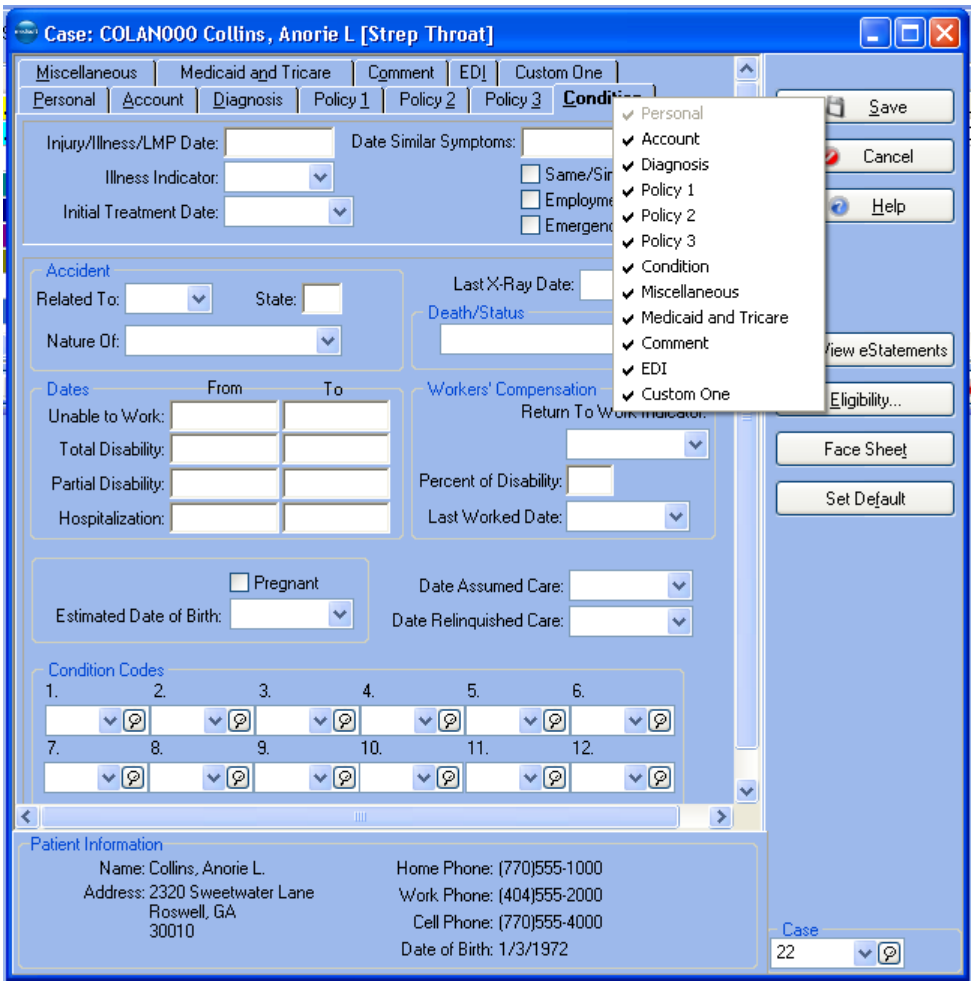

Figure 90. Case screen with tab list displayed

2. Click one of the tabs to deselect it. The tab is now hidden.
3. To display the tab again, right-click any tab header.
4. Click the hidden tab to place the check mark on it. The tab appears again.

Chapter 16 - Entering Transactions

Use the Transaction Entry screen to enter charges for procedures performed on patients. You can also enter co-payments here or adjustments to the patient's bill. When you open the screen and select a Chart (patient) and case number, Medisoft automatically collects information from the patient and case records and displays it in the screen. The top right section of the screen shows you the patient's balance, insurance information, and aging.

Medisoft is an Open Item Accounting program, meaning that transactions entered are marked when paid but remain on the active ledger as long as the case is active. There is no clearing of the ledger and bringing up a total to start a new month, as with a balance forward program.

To open Transaction Entry:

1. On the Activities menu, select **Enter Transactions.** The Transaction Entry screen appears.

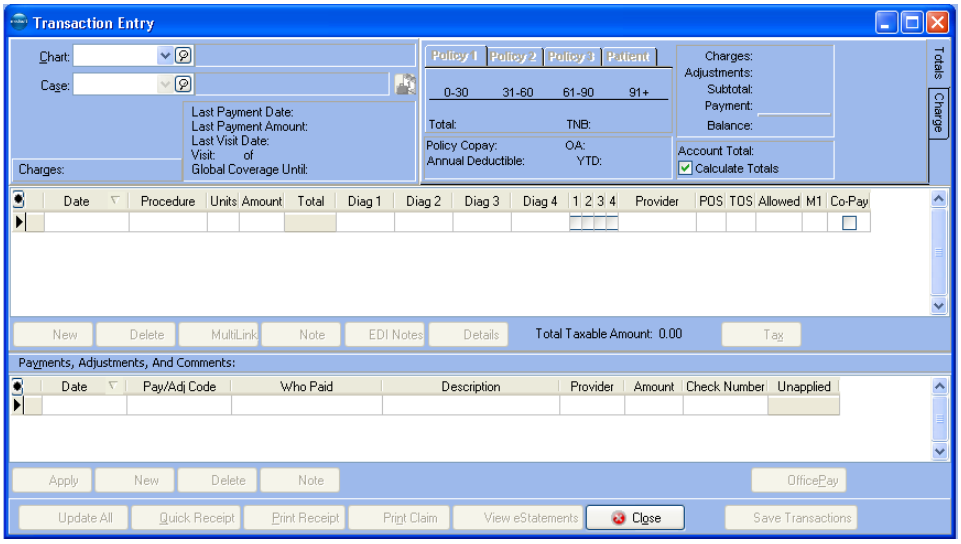

Figure 91. Transaction Entry screen

2. Select or enter a Chart (patient). The screen fills with patient information, including a Case number.

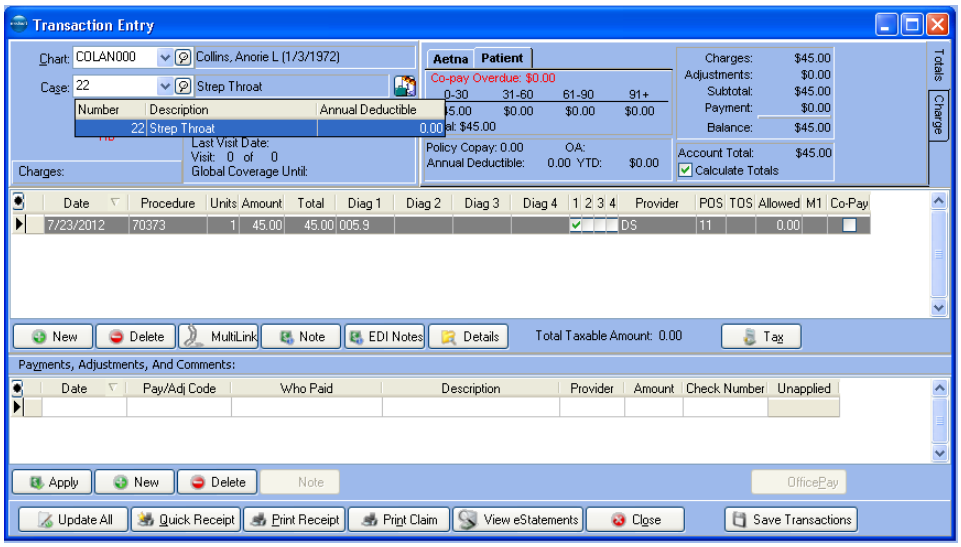

Figure 92. Transaction Entry screen with patient selected

You can choose a default for the case number that appears on the Data Entry tab in Program Options.

3. If necessary, change the case number.
4. To add a new charge, click **New** in the Charges section of the screen.
5. Select a Procedure and complete the remainder of the fields on the new charge line. Some of the information will be filled in automatically.
6. Enter further charge lines as necessary.
7. If you need to enter a patient's co-payment or other payments/adjustments, click **New** in the Payments, Adjustments, and Comments section of the screen.

8. Select a Pay/Adj Code and complete the line.

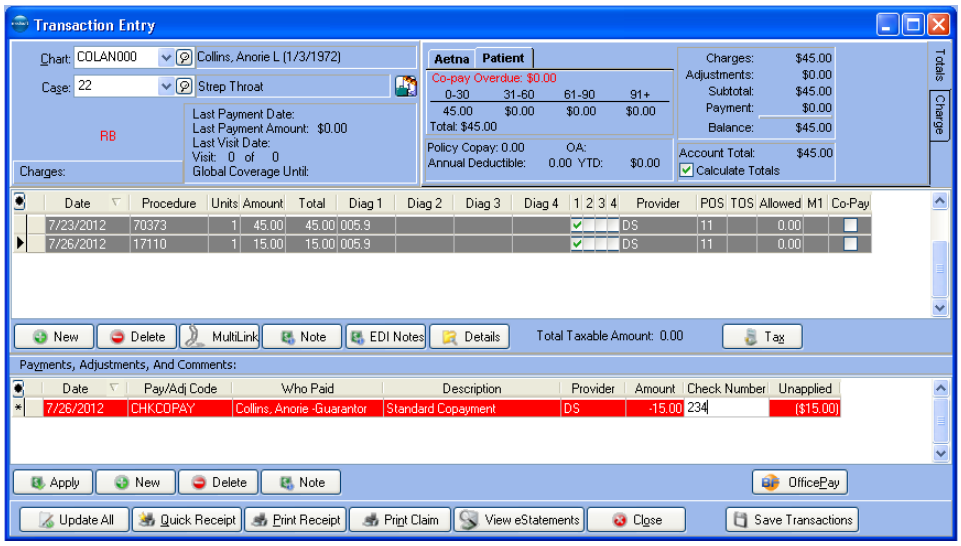

Figure 93. Transaction Entry screen with payment

9. To apply this payment to a charge, click **Apply**. The Apply Payment to Charges screen appears.

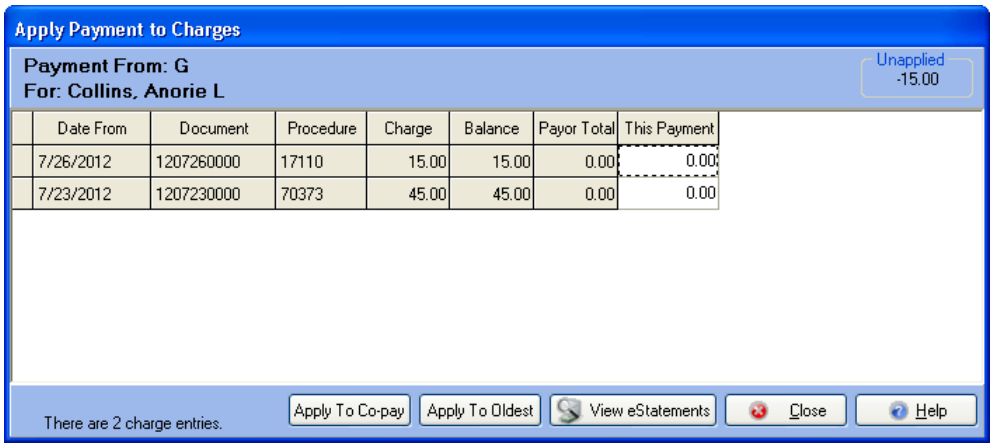

Figure 94. Apply Payment to Charges screen

10. Click in the This Payment check box and enter the amount to be applied.

    Option: Use the Apply to CoPay or Apply to Oldest buttons to automatically apply the payment.

11. Click **Close**. Note that the Unapplied amount on the payment line changes.

WARNING: McKesson recommends that you apply all payments and adjustments to charges. Failure to do so results in other parts of Medisoft not functioning properly, i.e., remainder billing and the delay secondary billing feature (Advanced and Medisoft Network Professional), to name only two. In addition, some report results will be incomplete or inaccurate.

12. Click **Tax** if you need to add sales tax to the charges.

13. Click **Note** if you need to add further detail for a charge line. This may include detail for claims.

14. Click **Save Transactions**.

Unprocessed Transactions

The Unprocessed Charges screen provides an interface between an Electronic Medical Records (EMR) service and Medisoft via Communications Manager (see "Communications Manager" on page 185). Transactions that come from the EMR appear here in an unposted state. As long as they are unposted, they will not be part of patient accounts and you cannot file claims on them or bill patients for them.

To open this screen:

1. On the Activities menu, select **Unprocessed Transactions.**
2. Select **Unprocessed EMR Charges**. The Unprocessed Charges screen appears with a list of transactions that have yet to be posted.

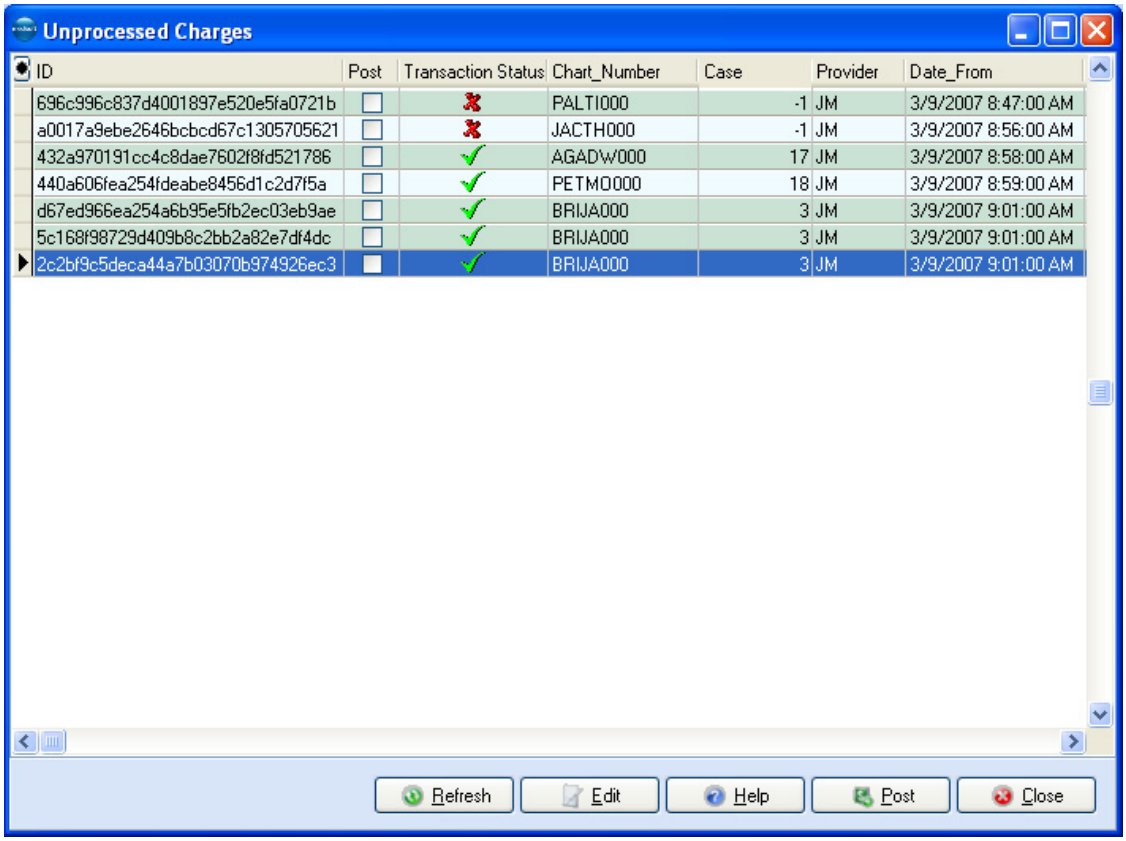

Figure 95. Unprocessed Charges screen

If there is a red x in the Transaction Status column for a line, click **Edit** to open the details and see the problem with the transaction.

3. Select the check boxes in the **Post** column for the transactions you want to post.
4. Click **Post** to update your patients' accounts.

Chapter 17 - Quick Ledger and Quick Balance

In this chapter you will learn about the Quick Ledger and Quick Balance features in Medisoft.

Quick Ledger

NOTE: This is an Advanced and Medisoft Network Professional feature.

The Quick Ledger gives a quick reference for transaction and other information in the patient's account. There are two types of Quick Ledgers in Medisoft: the Patient Ledger and the Guarantor Ledger.

The Patient/Quick Ledger displays transaction information and account totals for individual patients. The Patient Ledger is the default ledger.

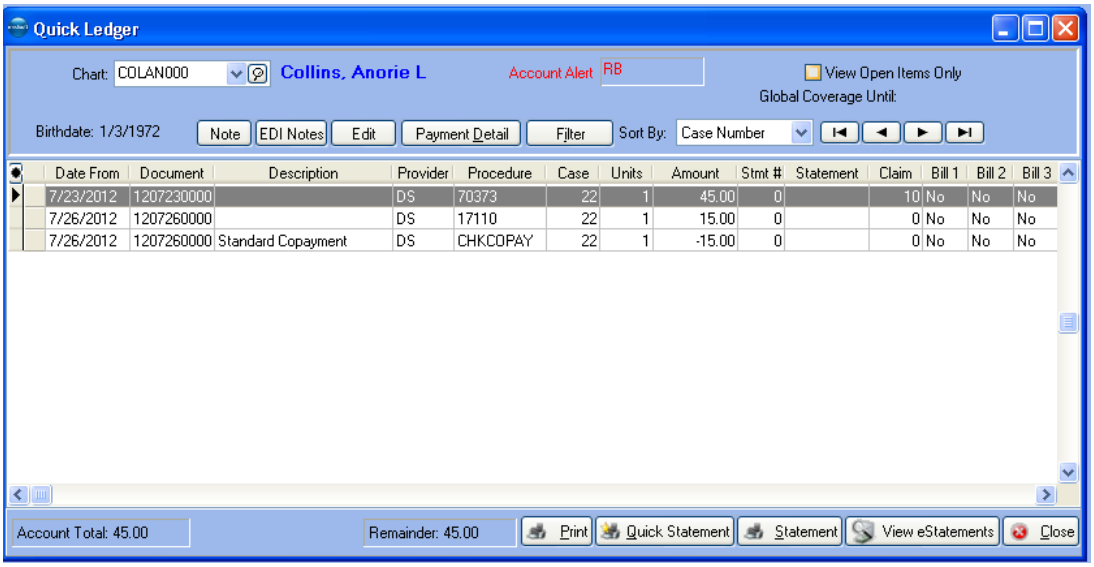

Figure 96. Quick Ledger screen

To open the Patient Ledger:

- On the Activities menu, select **Patient Ledger**.

The Guarantor Ledger provides the same information as the Patient Ledger but allows you to view guarantor totals as well.

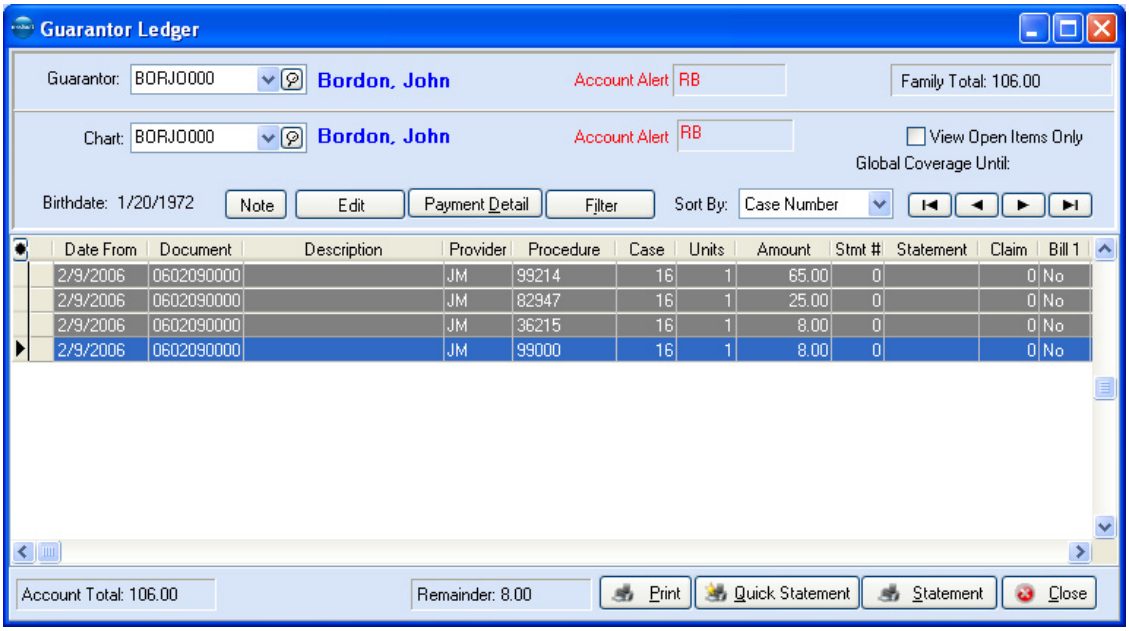

Figure 97. Guarantor Ledger screen

To get quick and easy access to a patient's ledger from almost anywhere in Medisoft, press **F7** or click the Quick Ledger speed button.

To open the Guarantor Ledger:

- On the Activities menu, select **Guarantor Ledger**.

While no new transactions can be made in the ledger itself, you can edit and print the ledger and gain valuable detail on patient accounts.

You can change responsibility for a selected transaction in the Quick Ledger screen. Right-click a transaction to change its responsibility between insurance carriers or from an insurance to the patient. This feature lets you skip entering the zero-dollar insurance payment to indicate that no payment is coming from the insurance carrier.

Click **Edit** or press **F9** to open the Transaction Entry screen where charges, payments, and adjustments can be reviewed and edited, as needed. Both the Patient and the Guarantor Ledgers let you view the notes entered for transactions and also add a note.
Click **Payment Detail** to display all payments/adjustments made toward a specific charge.

TIP: If you click **Quick Statement**, you will print statements from the Reports menu. If you click **Statement**, you will print statements from Statement Management. For more information in creating and printing statements, see "Creating Statements" on page 113.

Quick Balance

NOTE: This is an Advanced and Medisoft Network Professional feature.

The Quick Balance is a summary of all remainder charge totals for a selected guarantor record.

To open the Quick Balance screen:

- On the Activities menu, select **Quick Balance**.

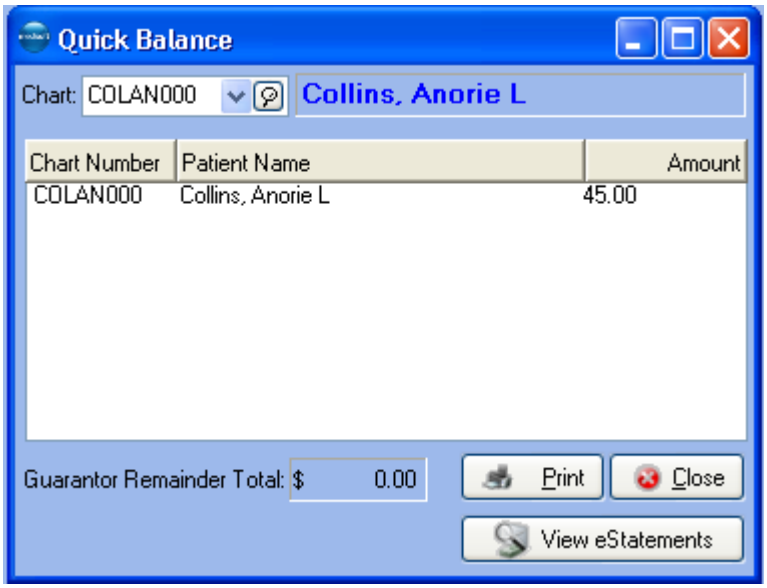

Figure 98. Quick Balance screen

If the record selected is a guarantor's record, the Quick Balance screen displays each patient for whom the guarantor is responsible and the total qualifying remainder charges for each. If the record selected is not a guarantor's record, you will see a listing of all the selected patient's balances.

TIP: If you click **Print** in Quick Balance, you will print statements from the Reports menu. For more information in creating and printing statements, see "Creating Statements" on page 113.

Chapter 18 - Creating Claims

In the chapter you will learn how to create claims in Medisoft.

Claim Management

This section explains briefly how to manage claims in Medisoft and includes creating, editing, printing/reprinting, and listing claims, as well as changing claim status.

The Claim Manager's Job

To help you better understand the function of claim management, consider this shipping analogy. Whereas Cases are containers filled with claims for specific diagnoses, claim management is the process by which the cases are checked, sorted, and delivered. In other words, claim management is the process of making sure all shipments are correct, ready to be sent, and shipped to the right companies (insurance carriers).

The Claim Manager (the person performing claim management) checks the claims, makes sure the boxes are properly marked, and sends them on their way. The Claim Manager determines whether the shipment goes by truck (paper claims) or by air (electronic claims). When a box is returned (rejected claim), the Claim Manager makes whatever changes are necessary (with help from the EOB [see "EOB" on page 185] or Audit/Edit Report) and ships the box again (resubmits the claim).

One person sees and treats the patients; another person enters data from the superbill (see "Superbill" on page 186) to begin the billing process. Once all the data has been entered, it must go through the Claim Manager's office before being sent to an insurance carrier.

The Claim Manager focuses on three principal areas, not necessarily sequential: review, batch, and final review.

- Watchdog: The Claim Manager is, first of all, the watchdog of the claims. The Claim Manager checks each claim and verifies the numbers, having the authority to edit the claim and make needed changes. If there is something in the claim that should go to a different carrier than indicated, or if the EDI receiver information is incomplete, the Claim Manager corrects the record. The Claim Manager also has access to the insurance carrier records and checks the billing date and how the claim is to be sent, either by paper or electronically. Then, the Claim Manager can indicate the status of the claim.
- Batch 'em up! The function of creating claims serves to group claims that are headed to the same destination. The Claim Manager gathers and sorts by range of dates or chart numbers. Transactions can be selected that match by primary carrier, Billing Code, case indicator, or location. Random Billing Code numbers can be selected. The Claim Manager can also indicate a minimum dollar amount for creating the claims, eliminating claims too small to be worth billing.

- Reviewer: There is also a List Only button that allows the Claim Manager to retrieve claims that match certain criteria that have been determined. The List Only Claims That Match screen is a “show me” screen that lets the Claim Manager review all that is in Medisoft.

Besides these three focus areas, the Claim Manager also has responsibility to mark claims that are paid and those that are rejected.

- Marking paid claims: The date of submission in the Claim Management screen indicates when the claims were shipped or transmitted. Claims are marked under the designation of “Sent” and the date is automatically inserted. The claims stay in Claim Management marked as “Sent” until they are manually changed in the Claim edit screen as having been received and dispatched by the carrier. When a payment is received, use the EOB to enter all payments through transaction entry.
- Handling rejected claims: When a paper claim is rejected for payment by the insurance carrier, the Claim Manager can change the payment status in the Claim Management screen from “Sent” to “Rejected.”

Creating Claims

To perform claim management functions, use the Claim Management screen. Here is where you create, edit, and print claims. Claims that will be sent electronically are created here but sent with Revenue Management, an integrated application that will send claims and receive payments. For more information on Revenue Management, see “Electronic Claims Processing” on page 137.

To create claims:

1. On the Activities menu, select **Claim Management**. The Claim Management screen appears.

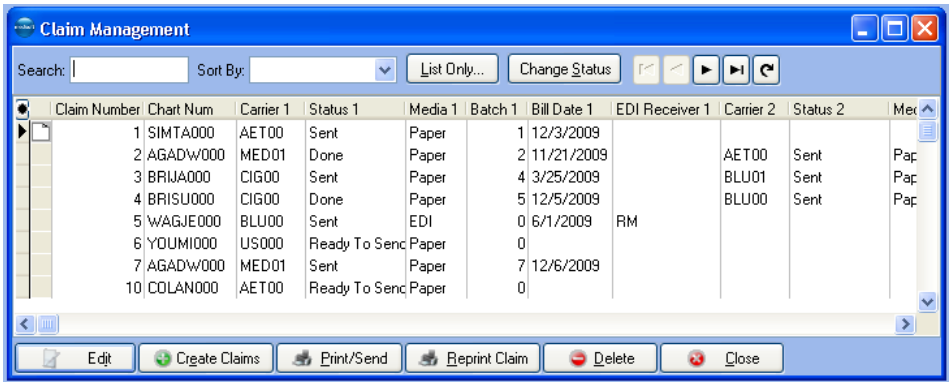

Figure 99. Claim Management screen

2. Click **Create Claims**. The Create Claims screen appears.

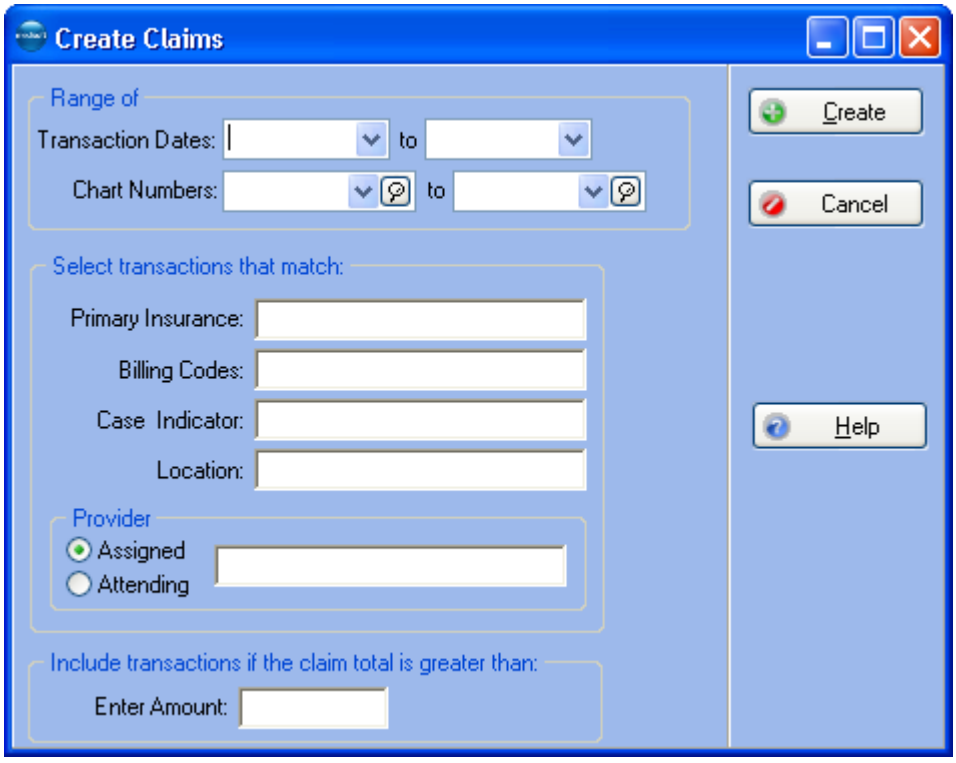

Figure 100. Create Claims screen

3. Use the fields on this screen to filter the ranges of dates, chart numbers, insurance carriers, and so on.

4. Click **Create**. The Claim Management screen appears and displays the claims that were created.

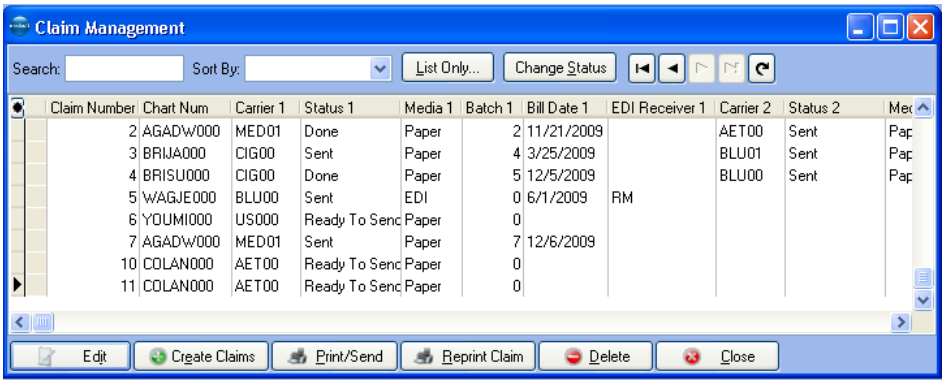

Figure 101. Claim Management screen with new claims.

Editing Claims

If a claim is rejected by the carrier, you will have to edit it so that it contains all of the information that the carrier wants.

To edit a claim:

1. On the Activities menu, select **Claim Management.** The Claim Management screen appears.
2. Highlight the claim you want to edit and click **Edit**. The Claim screen appears with the claim detail.

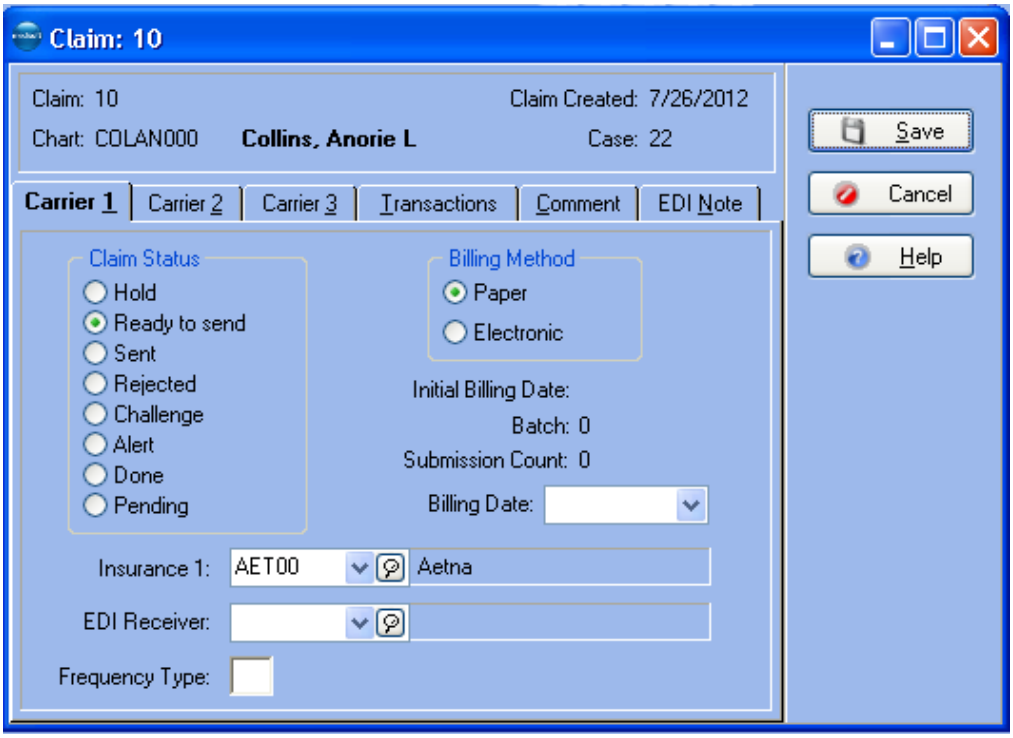

Figure 102. Claim screen

The Claim screen has several tabs that contain the information for the claim.

Tab	Description
Carrier 1, 2, 3	Use this tab to change the Claim Status, Billing Method, and the insurance carrier or EDI Receiver.
Transactions	Use this tab to see all of the transactions that are part of the selected claim. You can split, add, or remove transactions here.
Comment	Use this tab to place whatever comments you feel are necessary concerning this claim and/or any transactions relating to it. If you have Medisoft Advanced or Medisoft Network Professional, these notes will appear as a note icon in the **Claim Management** screen.
EDI Note	Use this tab to add information for EDI notes.

3. Revise the information on the tabs as necessary.
4. Click **Save**.

Printing Claims

If you print and send paper claims to clearinghouses and carriers, use the printing feature on the Claims Management screen.

1. On the Activities menu, select **Claim Management.** The Claim Management screen appears.
2. Click **Print/Send**. The Print/Send Claims screen appears.

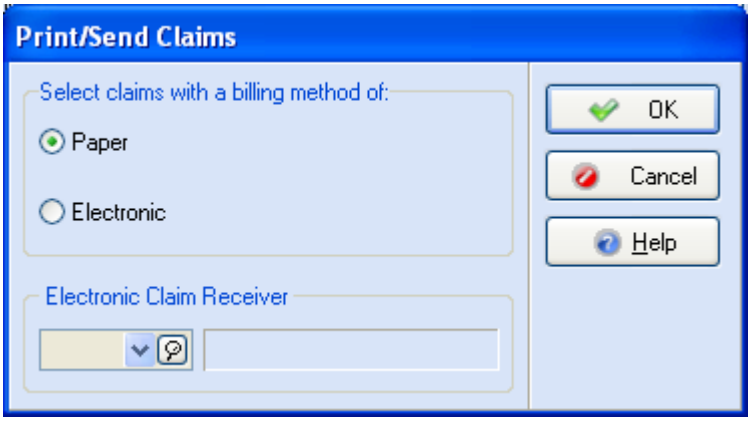

Figure 103. Print/Send Claims screen

3. Select **Paper** and click **OK**. The Open Report screen appears.

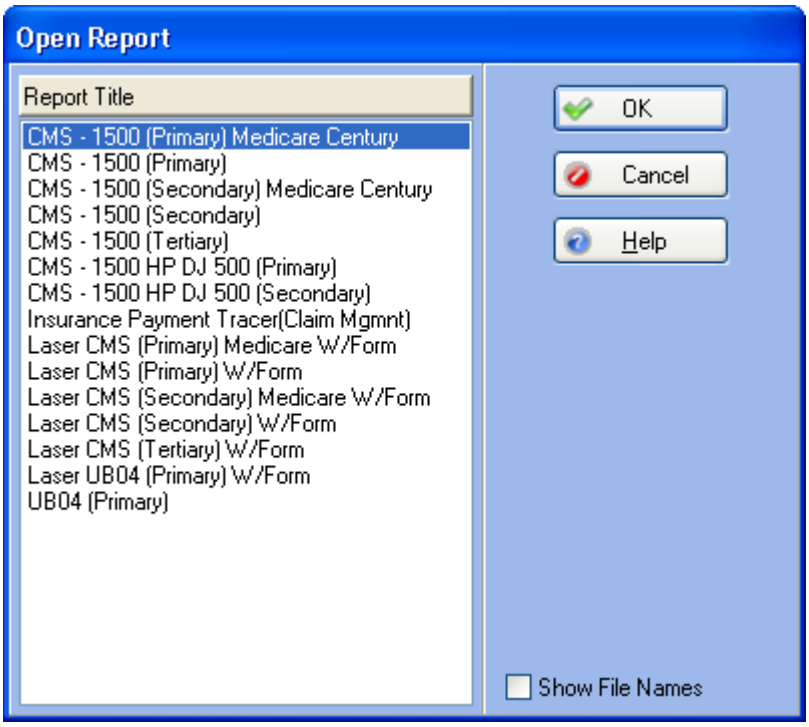

Figure 104. Open Report screen

4. Select which form you want to print on and click **OK**. The Print Report Where? screen appears.

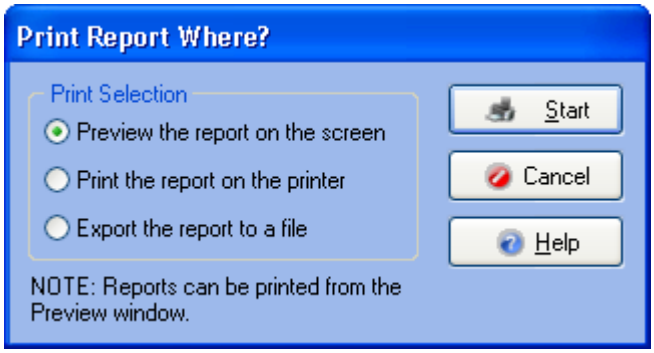

Figure 105. Print Report Where? screen

5. Select your option and click **Start**. The Data Selection Questions screen appears.

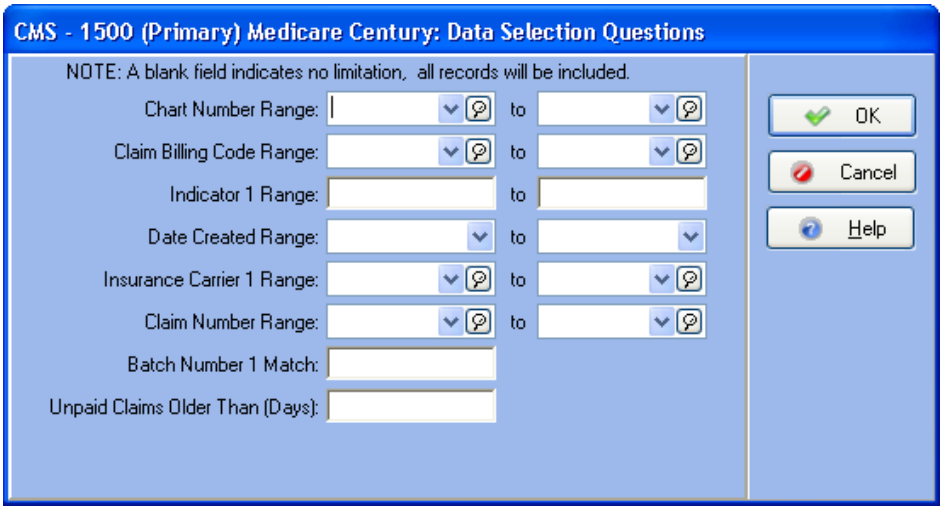

Figure 106. Data Selection Questions screen

6. Make your selections for the various ranges and click **OK.**

7. The Status of the claims will be updated to Sent on the Claim Management screen.

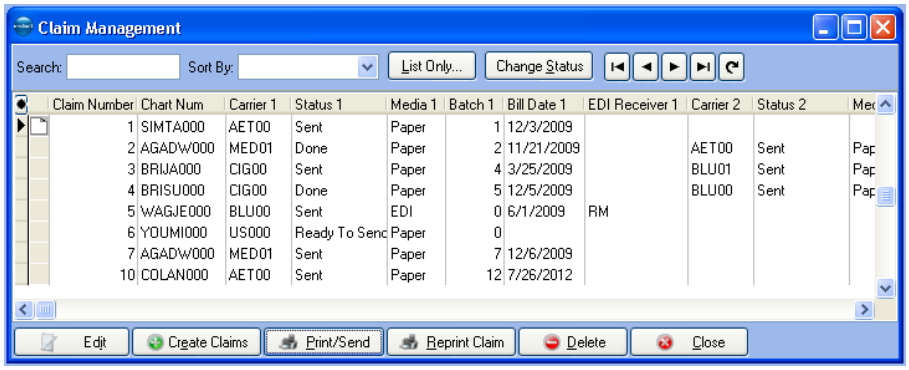

Figure 107. Claim Management screen with Status of Sent

Troubleshooting Insurance Claims

Claim Form Not Centered

If your insurance claims are printing off-center, you can fix this with the following steps:

1. On the Reports menu, select **Design Custom Reports and Bills**. The Medisoft Report Designer opens.
2. On the File menu of Medisoft Reports Designer, select **Open**. The Open Report screen appears.

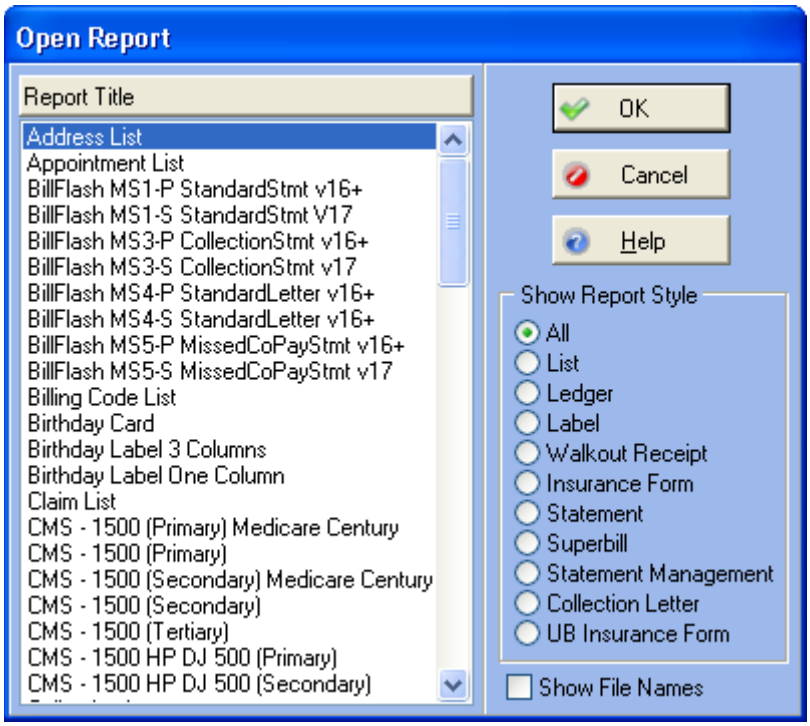

Figure 108. Open Report screen

3. Select the report form you use and click **OK**. The form opens.

4. On the File menu, select **Report Properties**. The Report Properties screen appears.

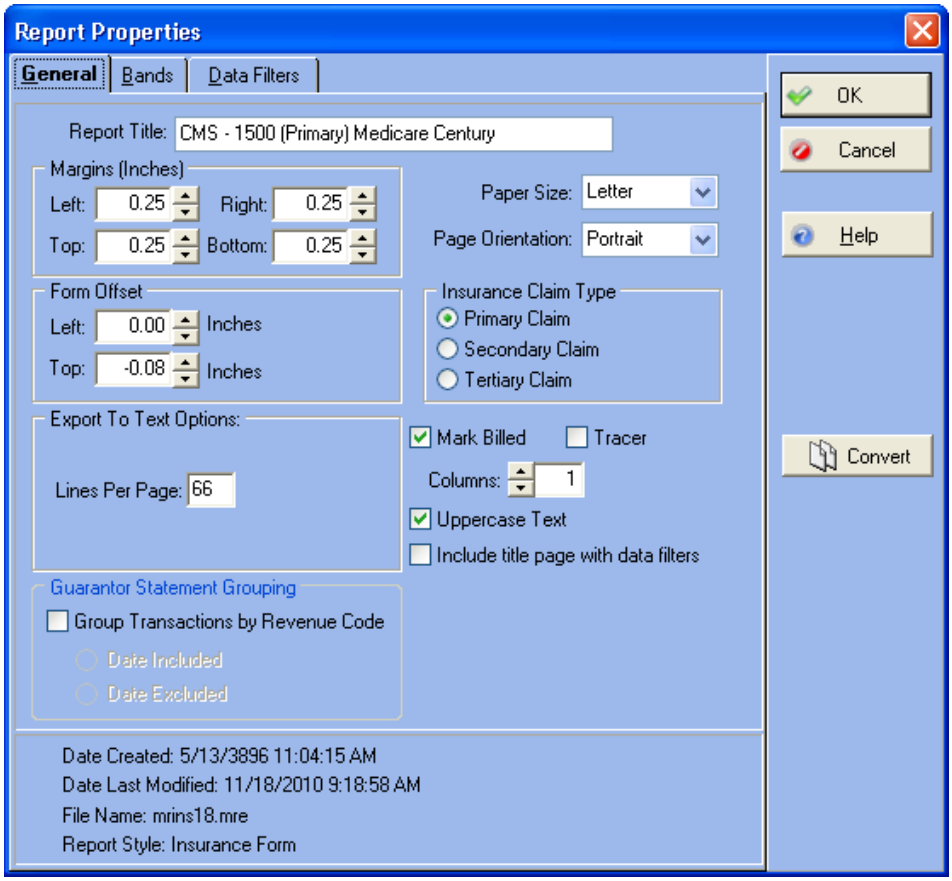

Figure 109. Report Properties screen

5. In the Form Offset section of the screen, adjust the form as necessary from the top and/or left margins. The form is moved in increments of one hundredth of an inch.
6. Click **OK**.
7. Save the report and close Medisoft Reports Designer.

Reprinting Claims

You can reprint claims if there is a problem with some of those that printed. To do so, follow the steps above on printing claims, except select Reprint Claim instead of Print/Send. See "Printing Claims" on page 107.

Changing Claim Status

In the Claim Management screen, all submitted claims are automatically marked Sent with an indication of the method of submission. There may be occasions when you need to change this status, for instance, if you need to resend them from Revenue Management.

Entire Batch

If the status of an entire batch needs to be changed, you can change all the claims at once.

1. Highlight one of the claims on the Claim Management screen and note the number listed in the Batch 1 column.
2. Click **Change Status**. The Change Claim Status/Billing Method screen appears.

Figure 110. Change Claim Status/Billing Method screen

3. Select **Batch** and enter the batch number from the Batch 1 column in the Claim Management screen.
4. Choose the appropriate buttons in the Status From and Status To sections.
5. Click **OK**.

Selecting Multiple Claims

1. When only one or a few claims within the same batch or claims from multiple batches need a status change, on the Claim Management screen, hold down the CTRL key and click each claim that needs the status changed. Note that the selected claims do not need to have the same claim status, but they will all change to the same status when you complete this procedure.
2. Click **Edit**.
3. In the Change Claim Status/Billing Method screen, select **Selected Claim(s)**
4. Select the appropriate buttons in the Status From and Status To sections.
5. If you have chosen claims with varying statuses, select **Any status type** in the Status From section.
6. Click **OK**.

Chapter 19 - Creating Statements

In this chapter you will learn how to create statements for billing your patients and updating them on charges to their accounts.

Statement Management

NOTE: This is an Advanced and Medisoft Network Professional feature.

This section explains briefly how to manage statements within the Statement Management screen and includes creating, editing, printing/reprinting, and listing statements, as well as changing statement status.

You can use Statement Management to create, bill, and rebill statements all from one place. You can also view information about the statement, such as the guarantor, the status, the initial billing date, and the type. You can also generate statements to track missed copays.

Creating Statements

When you want to bill your patients, create statements. You can print your statements to paper or you can use BillFlash to send them electronically. BillFlash will print and send your statements to your patients for you.

1. On the Activities menu, select **Statement Management**. The Statement Management screen appears. For more information on BillFlash, see "BillFlash Users" on page 44.

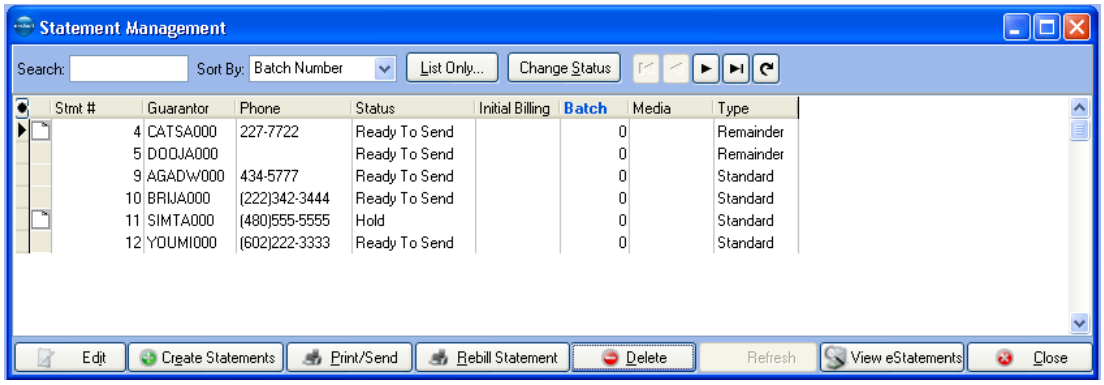

Figure 111. Statement Management screen

2. Click **Create Statements**.

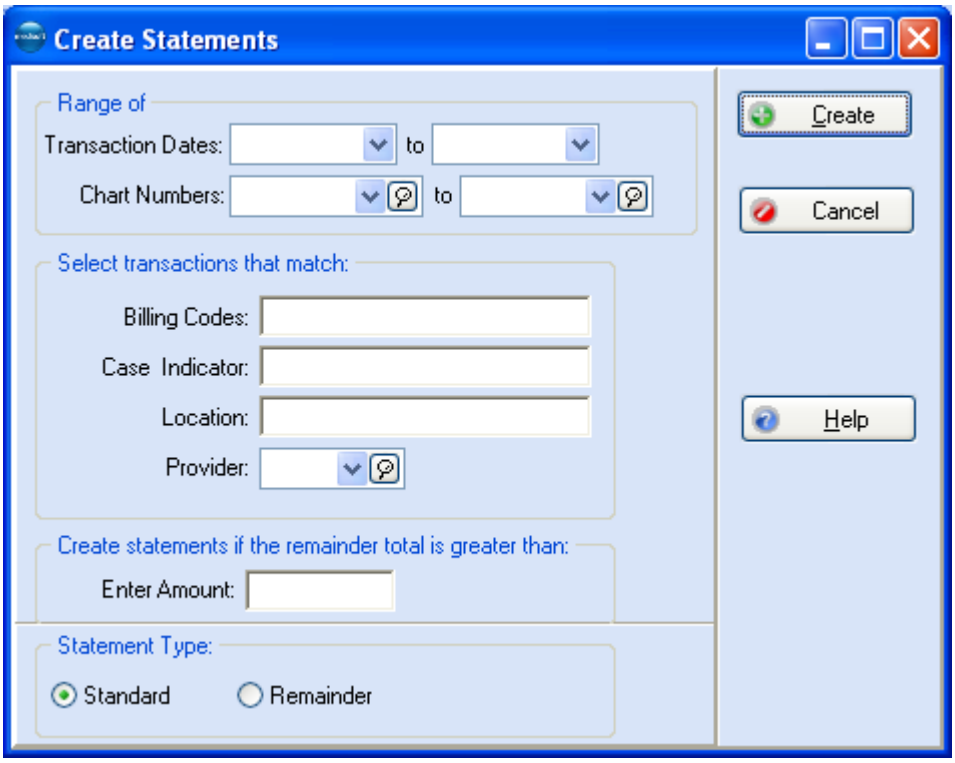

Figure 112. Create Statements screen

3. Enter ranges of transaction dates and/or chart numbers to control which statements are created, as well as other data for filtering the data.
4. Click **Create**. The system tells you how many statements were created.
5. Click **OK**. The new statements appear on the Statement Management screen.

Editing Statements

1. On the Statement Management screen, highlight a specific statement.
2. Click **Edit**. You can modify general statement information, the transactions that appear on the statement, and any comments attached to the statement. When you make changes in the Statement edit screen, you modify only that statement and do not affect the defaults for other statements.

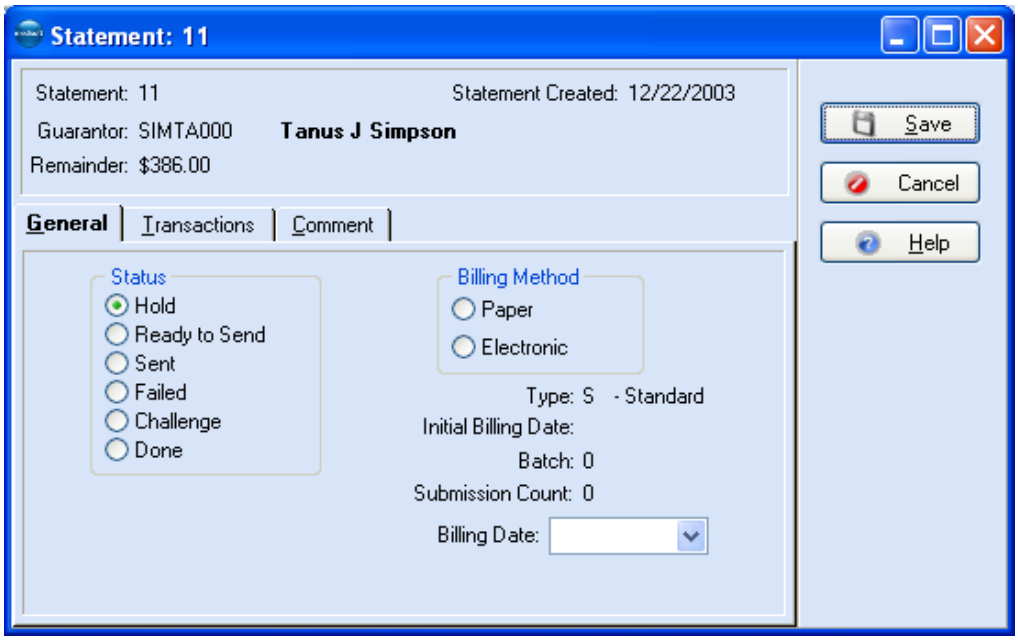

Figure 113. Statement screen

The Statement screen has three tabs that contain the information for the claim.

Tab	Description
General	Use this tab to change the Claim Status, Billing Method, and the billing date.
Transactions	Use this tab to see all of the transactions that are part of the selected statement. You can split, add, or remove transactions here.
Comment	Use this tab to place whatever comments you feel are necessary concerning this statement and/or any transactions relating to it.

3. Revise the information on the tabs as necessary.
4. Click **Save**.

Printing Statements

If you print and send paper statements to your patients, use the printing feature on the Statement Management screen.

1. On the Activities menu, select **Statement Management.** The Statement Management screen appears.
2. Click **Print/Send**. The Print/Send Statements screen appears.

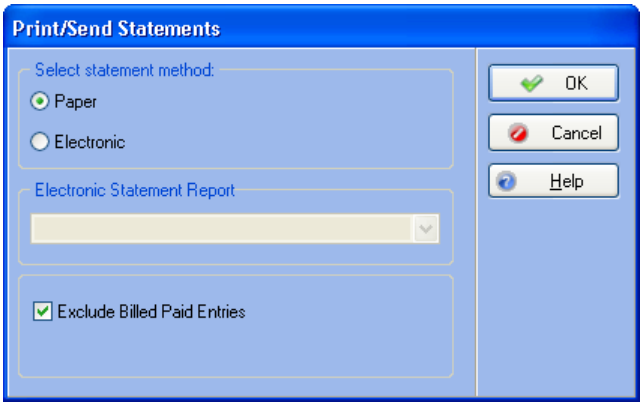

Figure 114. Print/Send Statements screen

3. Select Paper and click **OK**. The Open Report screen appears.

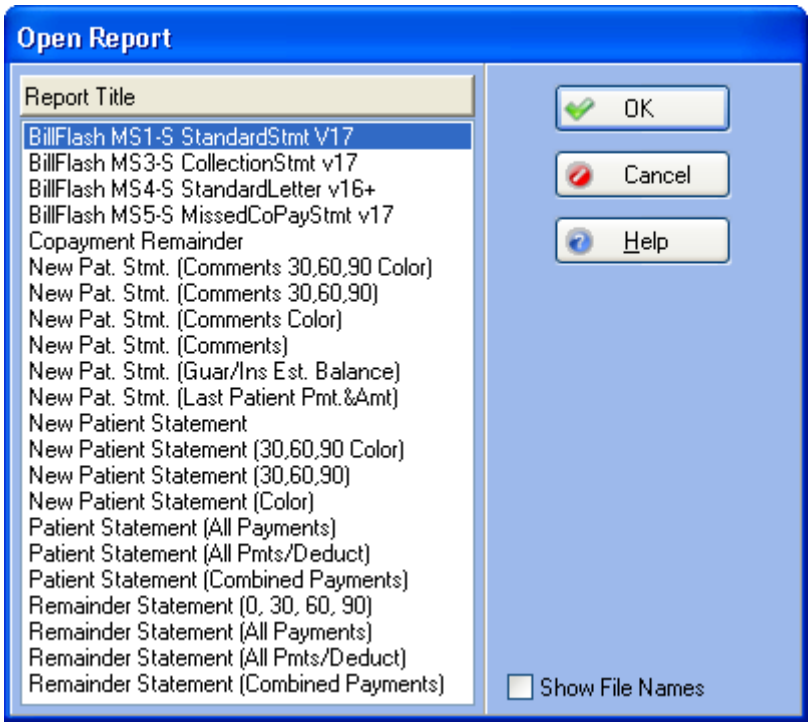

Figure 115. Open Report screen

4. Select which form you want to print and click **OK**. The Print Report Where? screen appears.

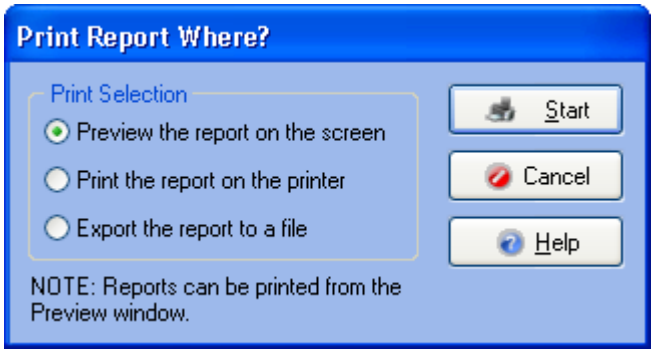

Figure 116. Print Report Where? screen

5. Select your option and click **Start**. The Data Selection Questions screen appears.

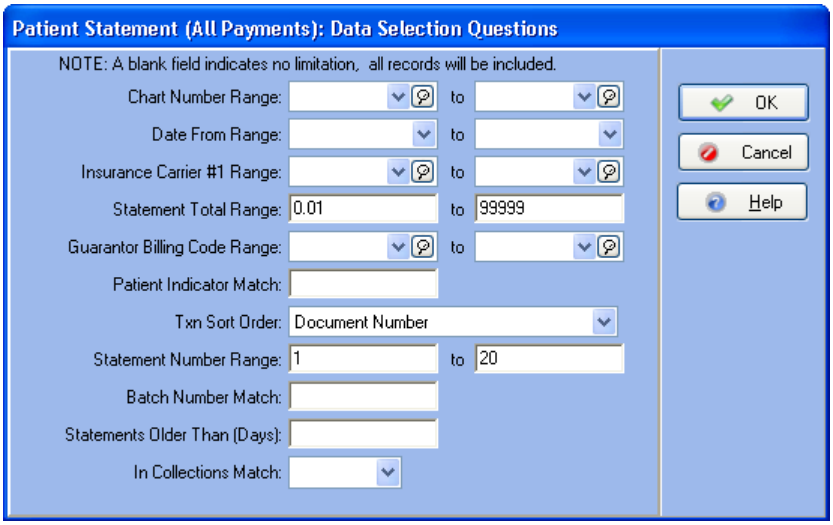

Figure 117. Data Selection Questions screen

6. Make your selections for the various ranges and click **OK.**

7. The Status of the claims will be updated to Sent on the Statement Management screen.

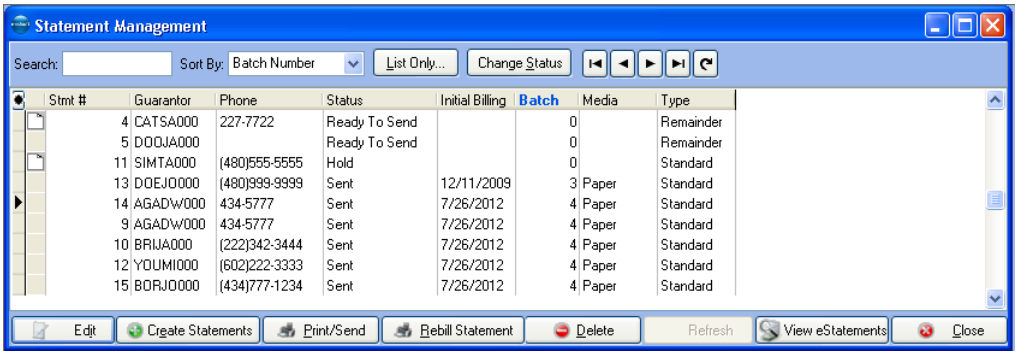

Figure 118. Statement Management screen with Status of Sent

Reprinting Statements

If necessary, you can reprint statements without regard to their status. To reprint an entire batch, the status must be changed for the batch.

Changing Statement Status

In the Statement Management screen, all submitted statements are automatically marked Sent with an indication of the method of submission. There may be occasions when you need to change this status.

Statements sent electronically through BillFlash get a report that marks each statement as either accepted or rejected.

Entire Batch

If you need to change the status of an entire batch, you can change all the statements at once.

1. On the Statement Management screen, highlight one of the statements and note the number listed in the Batch column.
2. Click **Change Status**. The Change Statement Status/Billing Method screen appears.

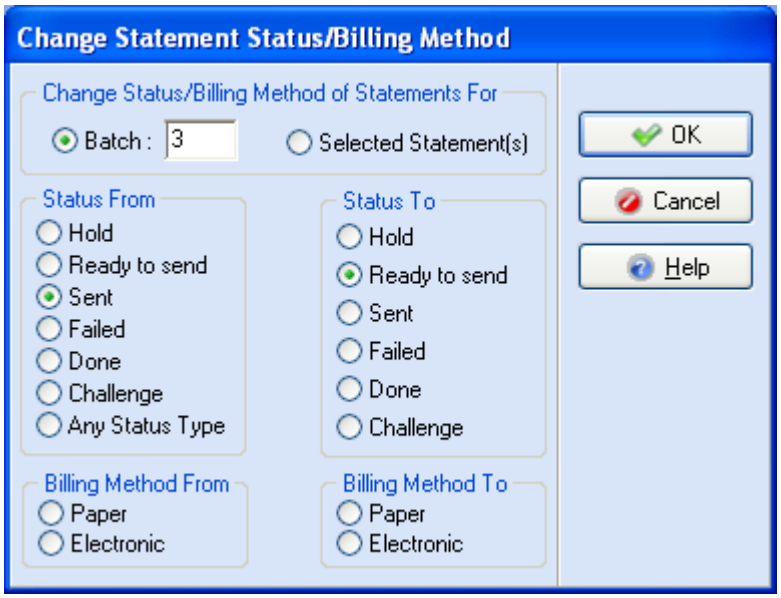

Figure 119. Change Statement Status/Billing Method screen

3. Select the **Batch** button and enter the batch number from the Batch column in the Statement Management screen.
4. Select the appropriate buttons in the Status From and Status To sections.
5. Click **OK**.

Selecting Multiple Statements

1. When only one or a few statements within the same batch or statements from multiple batches need a status change, on the Statement Management screen hold down the CTRL key and

click each statement that needs the status changed. Note that the selected statements do not need to have the same status, but they will all be changed to the same status.

2. Click **Edit**. The Change Statement Status/Billing Method screen appears.
3. Select **Selected Statement(s)**.
4. Select the appropriate buttons in the Status From and Status To sections.
5. If you have chosen statements with varying statuses, choose **Any Status Type** in the Status From section.
6. Click **OK**.

Billing Cycles

The cycle billing feature lets you print statements every certain number of days. If you want to print statements every 30 days, you can set up a billing cycle of that length.

Follow these steps to set up a billing cycle:

1. On the File menu, select **Program Options**. The Program Options screen appears.
2. Select the **Billing** tab.
3. Select the **Use Cycle Billing** check box.

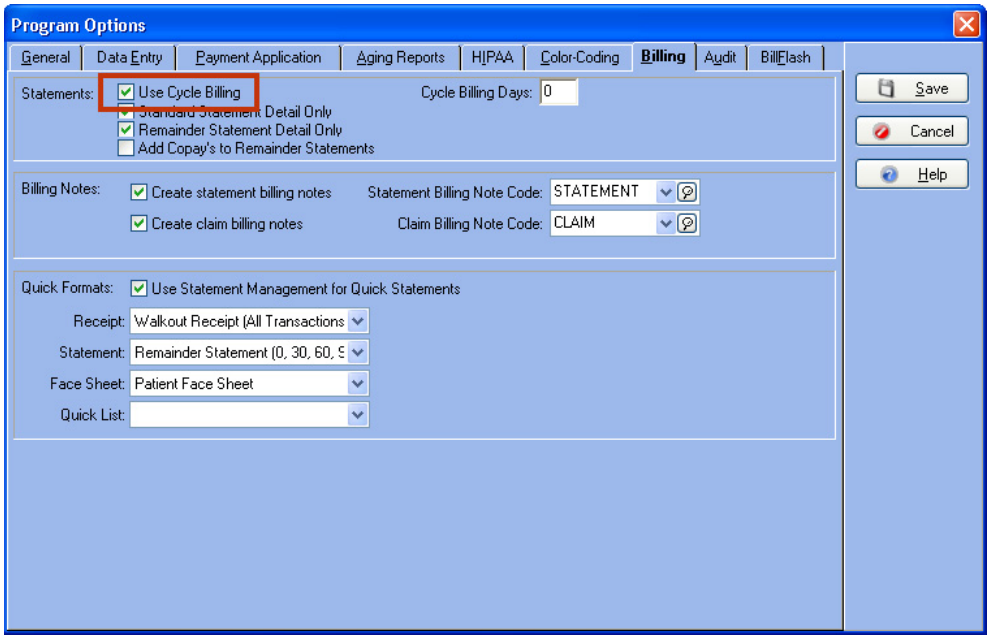

Figure 120. Program Options screen, Billing tab

4. Enter a number in Cycle Billing Days. The number of days indicates the length of your billing cycle.
5. Click **Save**.

Now, after you click Print/Send on the Statement Management screen, Medisoft will automatically print statements based on the Next Statement Date of each statement. If the Next Statement Date is on or before the current date, the statement prints. If you have never printed statements with the

billing cycle turned on, statements are printed according to the Last Statement Date stored in the statement record. If the Last Billing Date plus the billing cycle interval is on or before the current date, the statement prints.

NOTE: Statements might not print if they are filtered out by report selection questions or by predefined statement processing rules.

The program updates the statement's Next Statement Date for the next time you process statements.

Troubleshooting Statement Printing

Patient Remainder Statements

NOTE: This is an Advanced and Medisoft Network Professional feature.

If you are having trouble printing patient remainder statements, check to be sure the following items have been performed:

- The patient has insurance coverage other than Medicare. This is indicated in the patient Case screen, Policy 1 tab, Insurance 1 field (also Policy 2 and Policy 3 tabs if there is secondary and/or tertiary coverage).
- A charge has been posted in the patient case.
- A claim has been created.
- An insurance payment or adjustment has been posted, applied, and marked as Complete to the account for each applicable carrier.

Chapter 20 - Applying Deposits/Payments

NOTE: Deposits/Payments is an Advanced and Medisoft Network Professional feature.

Although you can enter payments in transaction entry for patient copays, you can also enter payments using Deposit/Payment. This option makes creating a deposit list and applying payments, especially payments from insurance carriers, an easy process. The advantage to this option is that you can apply a payment toward several cases and charges from the same screen.

Entering a Payment

To enter a payment:

1. On the Activities menu, select **Enter Deposits/Payments**. The Deposit List screen appears.

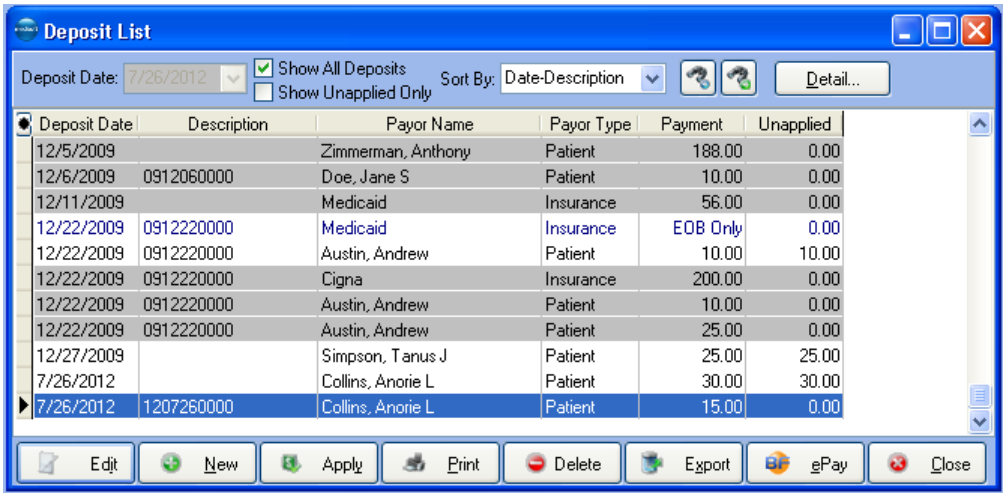

Figure 121. Deposit List screen

2. Click **New**. The Deposit (new) screen appears.

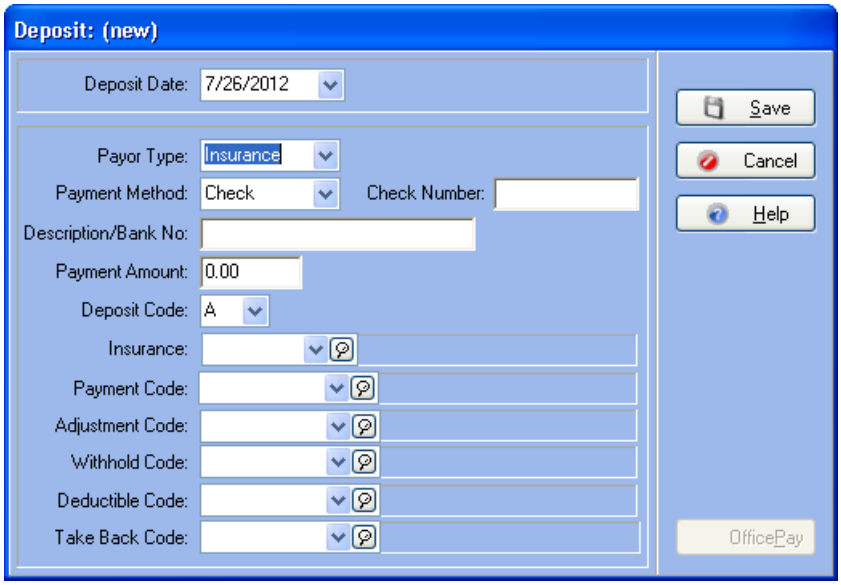

Figure 122. Deposit (new) screen

3. Select the appropriate Payor Type. Depending on your selection, the fields on the screen will change.
4. Complete the remaining fields as necessary, specifying the insurance or patient who paid.
5. Click **Save**. The new payment appears on the Deposit List screen and is highlighted. It is now available to be applied to charges.

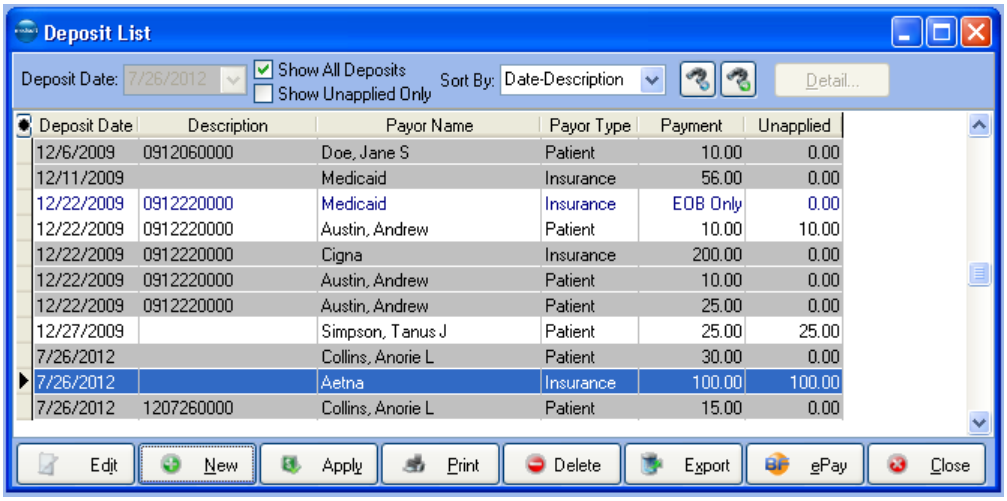

Figure 123. Deposit List screen with new payment highlighted

Applying a Payment

1. On the Activities menu, select **Enter Deposits/Payments.** The Deposit List screen appears.

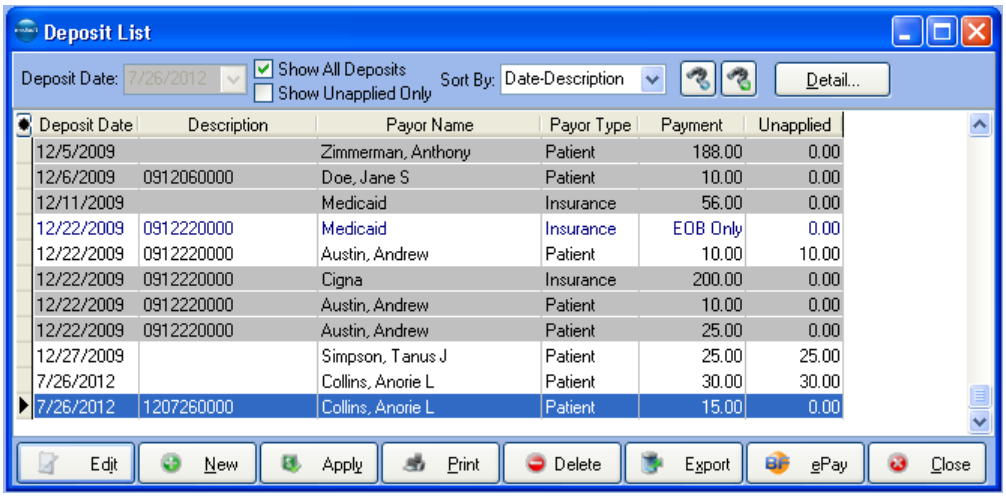

Figure 124. Deposit List screen

TIP: To save time and increase work efficiency, you can close a case after applying payment by right-clicking the line item in the grid and then selecting Close Case.

2. Highlight a payment and click **Apply**. The Apply Payment/Adjustments to Charges screen appears.

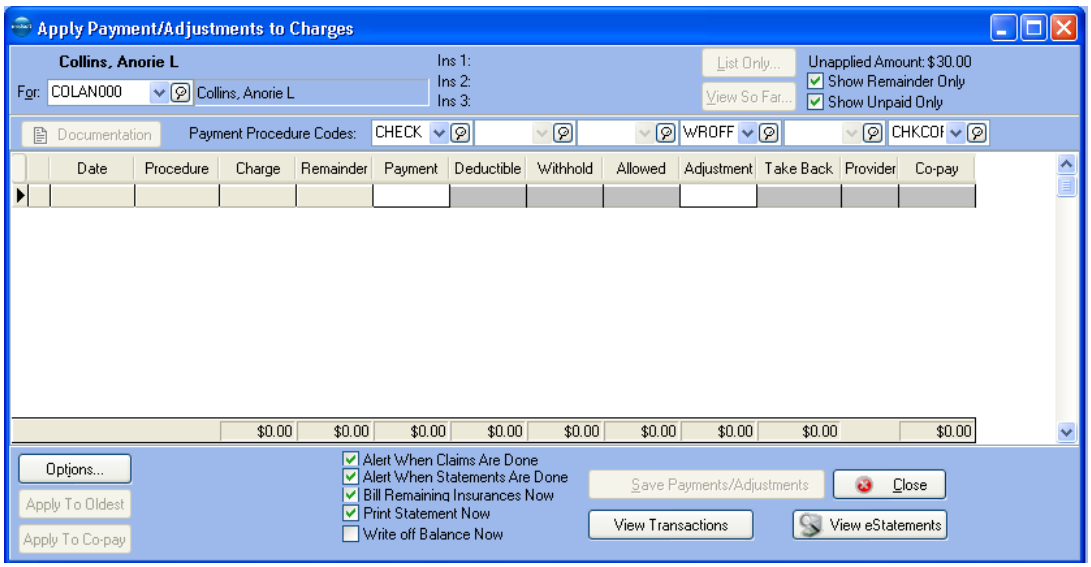

Figure 125. Apply Payments/Adjustments to Charges screen

3. Select the patient chart number (if you have chosen an insurance payment)

4. Apply the portion of the payment to the applicable charge(s).

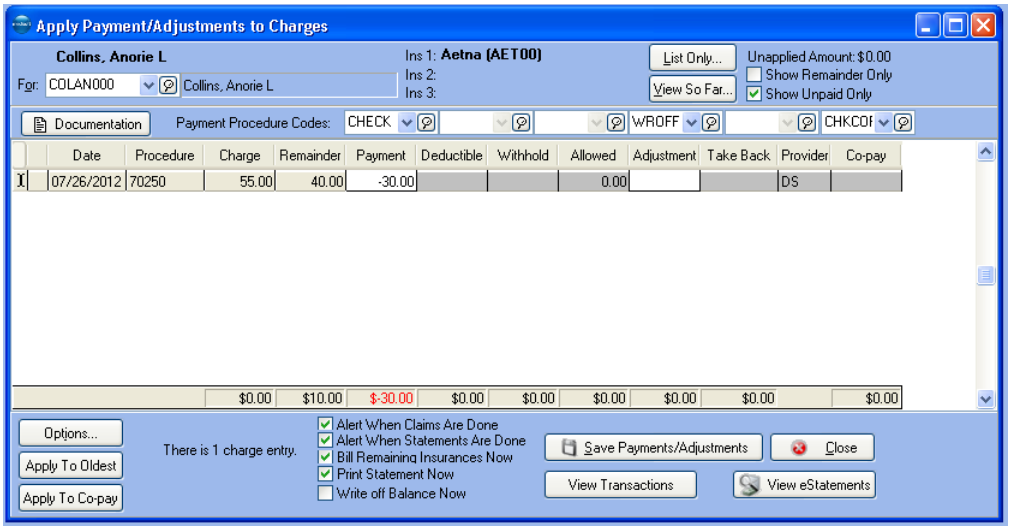

Figure 126. Apply Payment/Adjustment to Charges screen

5. Click **Save Payments/Adjustments**.

TIP: If you select the Print Statement Now check box and click **Save Payments/Adjustments**, you can print statements from Statement Management.

6. If you need to apply payments from the same deposit to another patient record, select the next patient chart number and continue making payment applications.

   This screen is also tied to the Payment Application tab of Program Options. Unless deactivated, all payment applications are automatically checked as paid in full by the payer, allowed amounts are calculated on all charges, and any charges over the calculated allowed amounts are automatically entered in the Adjustment field. You can open and change Program Options that are applicable to this screen by clicking Options in the bottom left of the screen

TIP: Be sure to click **Save Payments/Adjustments** before closing this screen or transactions cannot be created.

7. Click **Close**.

EOB Payments

Part of the payment structure to a healthcare office from an insurance carrier involves a check and an Explanation of Benefits. Widely known throughout the industry as the EOB, it lists claims for which payment is being made and, in some cases, an explanation of what is not being paid and why.

Not every insurance claim that is filed with a carrier is paid in full. It may be that payment is 80 percent of the claim or it may be 50 percent. Other times a claim may be totally or partially disallowed. The EOB explains in these cases. Normally, the part that is not paid by the carrier is picked up by a secondary carrier or charged back to the patient.

When a payment is received, a transaction must be entered to offset the charges. This is done by creating a deposit in the Deposit List screen. If the payment covers several charges, distributing a payment to specific charges can be handled by clicking Apply. Then, select the patient records and claims to be paid and designate how much goes to each.

Managed Care

One of the important sources of patients and income in many practices are managed care organizations. An HMO or PPO provides a list of patients who have selected your practice as their primary care provider. Payment is made to your practice on a per-patient basis, regardless of whether the patient ever visits the office. When a patient does come in for treatment, he or she pays a set co-pay amount.

The co-pay is charged only by the primary care facility or the facility to which the patient is referred by the primary care facility. After a patient's visit to the physician's office, a claim is filed and sent to the carrier. When the EOB is returned, there is seldom a payment included, since payment is made under the capitation program for managed care organizations.

Capitation Payment

The basis for capitation payments is to provide healthcare for a fixed cost, irrespective of the amount of service required by each individual patient. This is done in connection with the managed healthcare services such as HMOs and PPOs. There is no direct relationship between the capitation payment received by the practice and the number of patients covered by the plan who actually visit the practice for treatment. Capitation payments are not posted to patient accounts but are entered in the Deposit List screen. If it is necessary to zero out a patient account, create a zero deposit for the carrier. For each patient covered by the capitation payment who has an outstanding balance, zero out the account by entering the remainder in the Adjustment field. When it is applied, the payment shows as zero and the patient's balance shows as a write off in the Adjustment field in the Transaction Entry screen.

ePayments

If you have enrolled with BillFlash and patients are making payments online directly to BillFlash, you can download these payments to your practice by clicking ePay on the Deposit List screen. Medisoft will capture these payments and display them in the Deposit List screen. Then, you can apply them to charges.

Chapter 21 - Managing Collections and Small Balance Write-Offs

In this chapter you will learn about managing collections and writing off balances that you know will never be paid.

Collection List

The Collection List is a central place where you can manage accounts that are in collections. Ticklers or collection reminders are displayed as collection list items.

To open the Collection list,

- On the Activities menu, select **Collection List**. The Collection List screen appears.

You must activate Security and create user logins before this feature can be used. For more information on security, see "Security Setup Overview" on page 35.

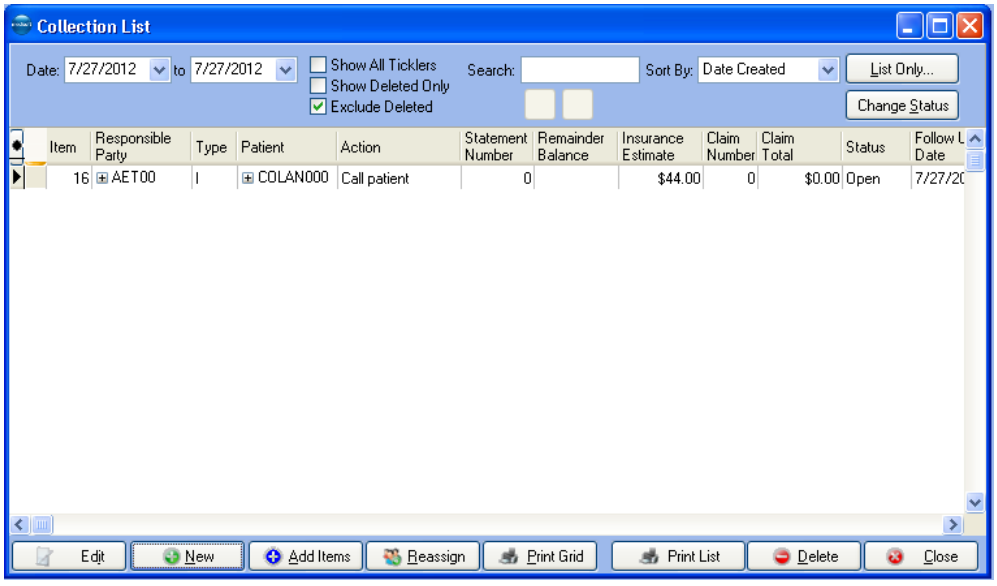

Figure 127. Collection List screen

What appears in the collection list depends on the user login. Medisoft displays the collection list item for the current user, unless the user has administrative access. Administrators can choose to view all or selected users' collection list items.

Adding a Tickler

"Ticklers" are notes you enter for the Collection List that remind you to make efforts to collect on overdue patient accounts.

To create a new tickler:

1. On the Collection List screen, click **New**. The Tickler Item screen appears.

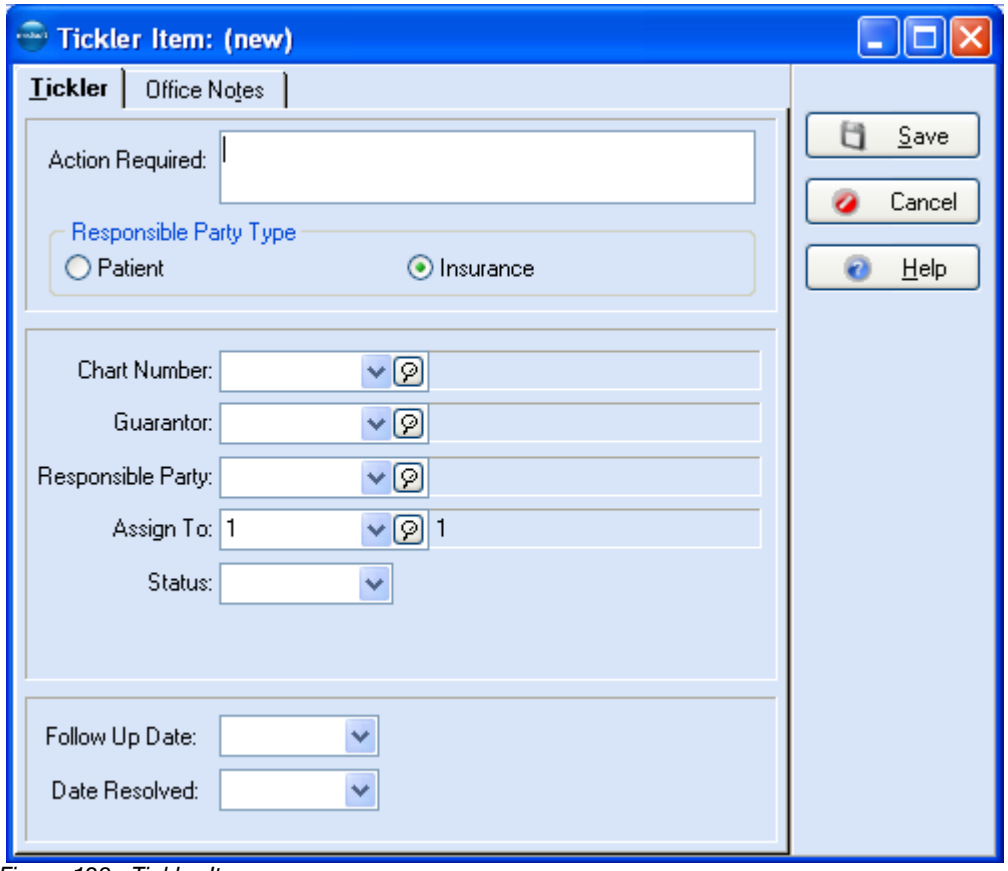

Figure 128. Tickler Item screen

2. Complete the fields as necessary.
3. Click **Save**. The new item is added to the Collection List. Once a tickler is created for this patient, you can create collection letters.

Adding Collection List Items

Use this screen to create multiple ticklers at once, based on criteria you enter here.

1. On the Collection List screen, click **Add Items.** The Add Collection List Items screen appears.

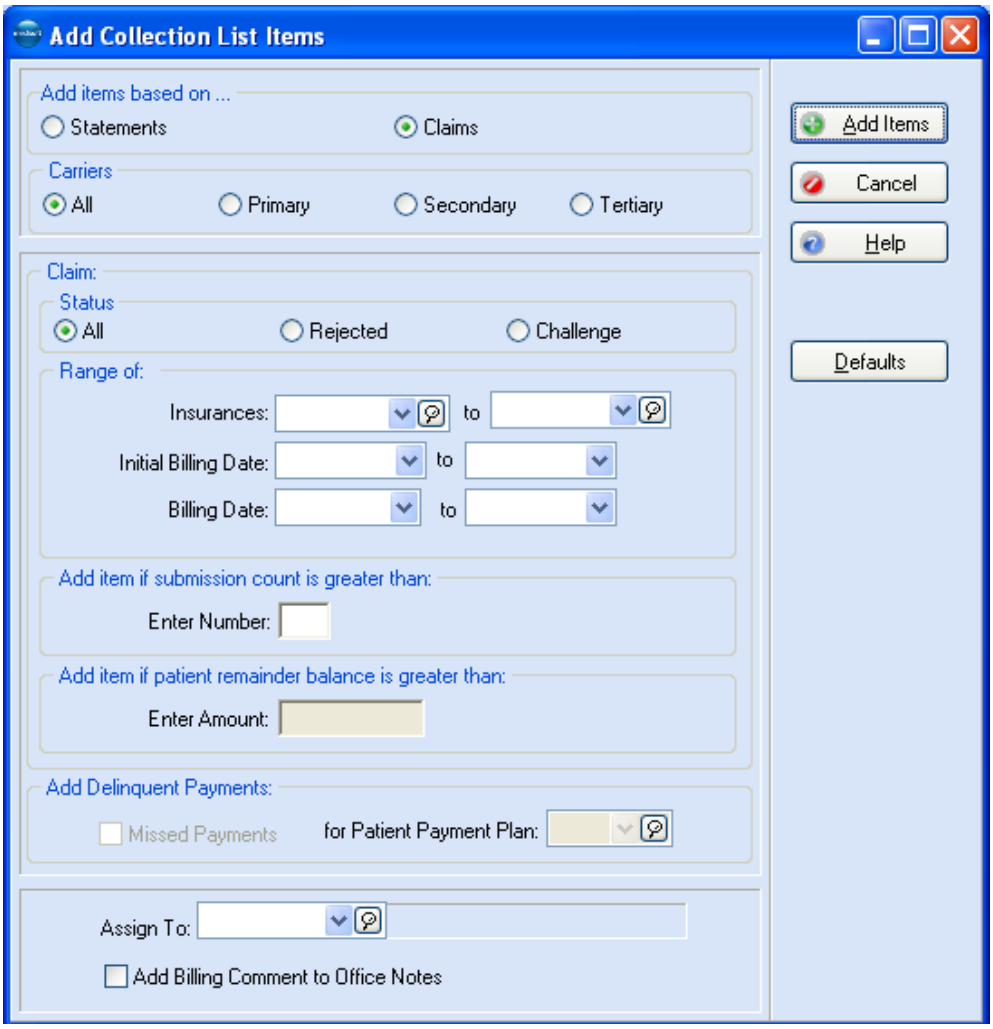

Figure 129. Add Collection List Items screen

2. Make your selections here from the various filters and options. Note that you can also assign these new ticklers to a specific user.
3. Click **Add Items**. The new items appear on the Collection List.

Patient Payment Plans

To help patients make consistent payments on their accounts, you can create payment plans. You can create as many plans as necessary to accommodate your patients.

Creating a New Plan

1. On the Lists menu, select **Patient Payment Plan**. The Patient Payment Plan List screen appears. From here, you can see all of the existing payment plans. You can add a new plan, edit an existing plan, or delete a plan.

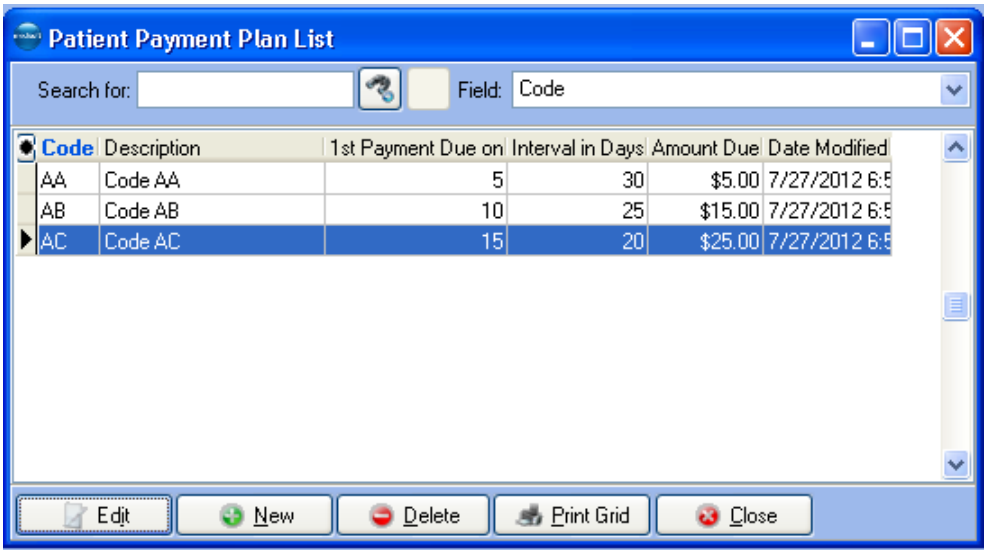

Figure 130. Patient Payment Plan List screen

2. Click **New**. The Patient Payment Plan screen appears.

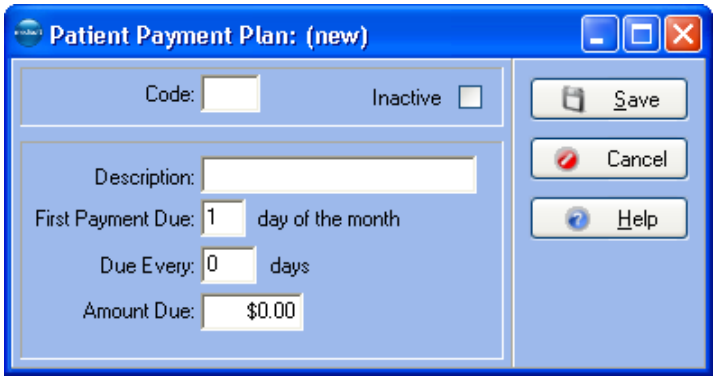

Figure 131. Patient Payment Plan screen

3. Complete the fields for the new plan.
4. Click **Save**.

Applying a Plan to a Patient

Once you create a plan, add it to the patient's record.

1. On the Lists menu, select **Patients/Guarantors and Cases.** The Patient List screen appears.
2. Highlight the patient whose record you want to update and click **Edit Patient**.
3. Select the **Payment Plan** tab.

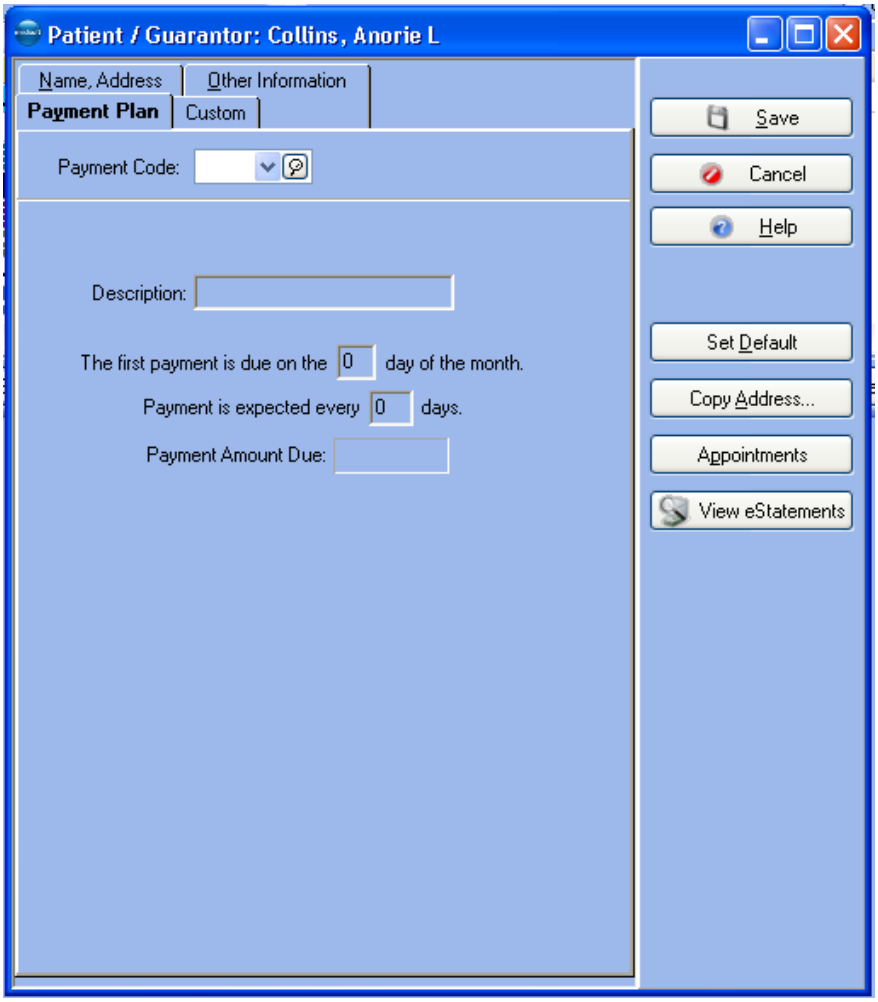

Figure 132. Patient/Guarantor screen, Payment Plan tab

4. Select the appropriate code in the Payment Code field. The details of the plan appear on the tab.
5. Click **Save**.

Medisoft records and tracks the scheduled date for the next payment and the amount to be applied. If the patient follows the payment plan, their account will not be included when you process collection letters. If the patient does not follow the payment plan, their account will be included when you process collection letters.

Collection Letters

Once you put a patient-responsible account in collections, you can create collection letters to follow up with the patient.

To print collection letters:

1. On the Reports menu, select **Collection Reports**.
2. Select **Patient Collection Letters**. The Print Report Where? screen appears.

You must print the Collection Letter Report before you print collection letters.

3. Select one of the options and click **Start**. The Data Selection Questions screen appears.

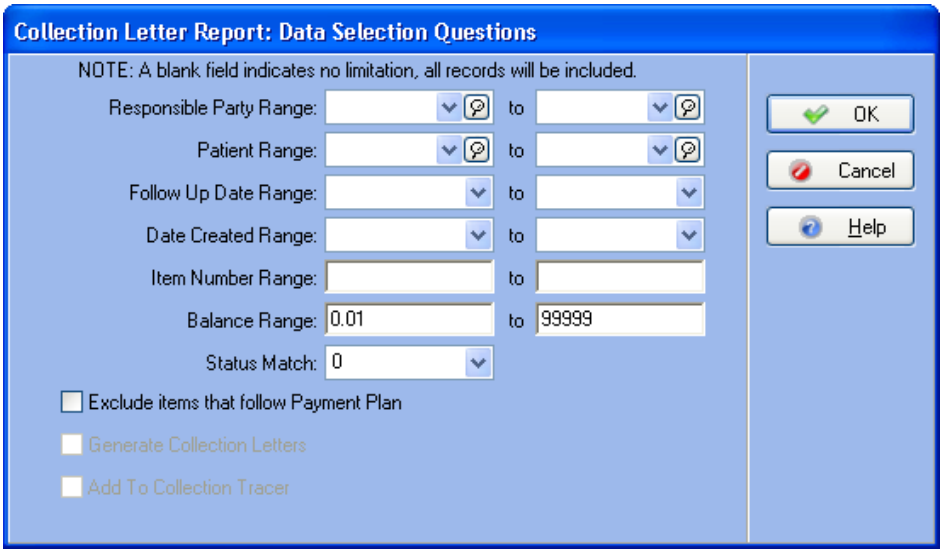

Figure 133. Data Selection Questions screen

4. Make your selections for filtering data.
5. Select the **Exclude items that follow Payment Plan** check box to activate the Generate Collection Letters box.
6. Select the **Generate Collection Letters** check box.
7. Click **OK**.
8. Click **Yes** to the question “Do you want to print collection letters?” The Open Report screen appears.
9. Select the form and click **OK.** The Print Report Where? screen appears.
10. Make your selection and click **Start**.

Customizing Collection Letters

Customize the collection letter format through the Collection Letter Wizard.

1. On the Tools menu, select **Collection Letter Wizard**. The Collection Letter Wizard screen appears.

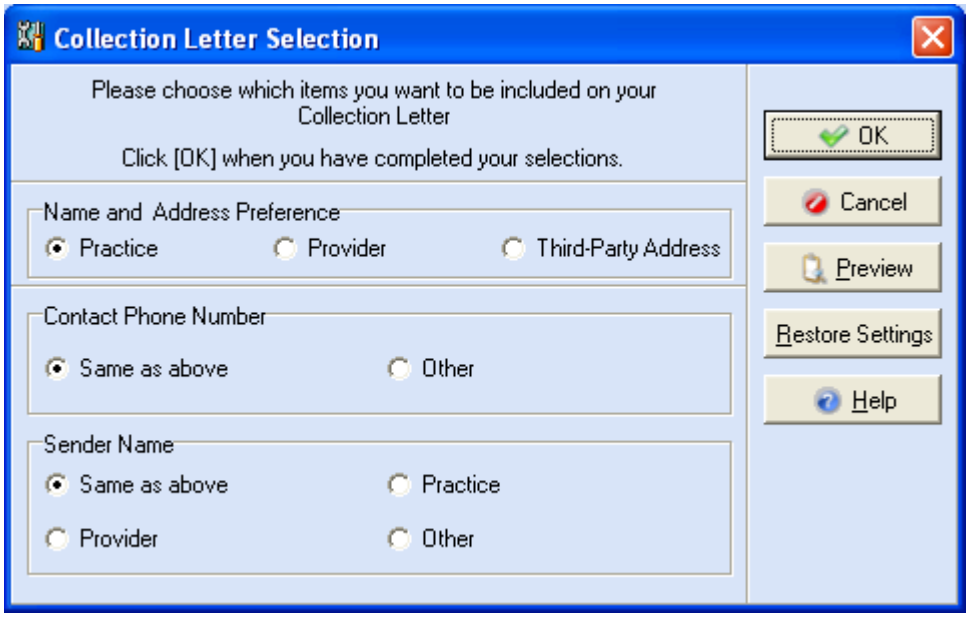

Figure 134. Collection Letter Selection screen

2. Make your selections and click either **OK** or **Preview**.

Access the new format through the Custom Report List. New formats are named WzCollections date (using the date on which the format was revised). If you create several new formats in a single day, you can distinguish them by the order in which you created them. Click **Show File Names** to reveal the format file names. This shows the file names, type, and date and time last modified.

Small Balance Write-off

This feature lets you automatically write off remainder balances of a certain amount. The balance written off is the patient remainder balance. You can write off small remainder balances as a batch in the Small Balance Write-off screen or for one patient at a time in the Apply Charges/Adjustments to Payments screen.

Writing off a Balance

1. On the Activities menu, select **Small Balances Write-off**. The Small Balance Write-off screen appears.

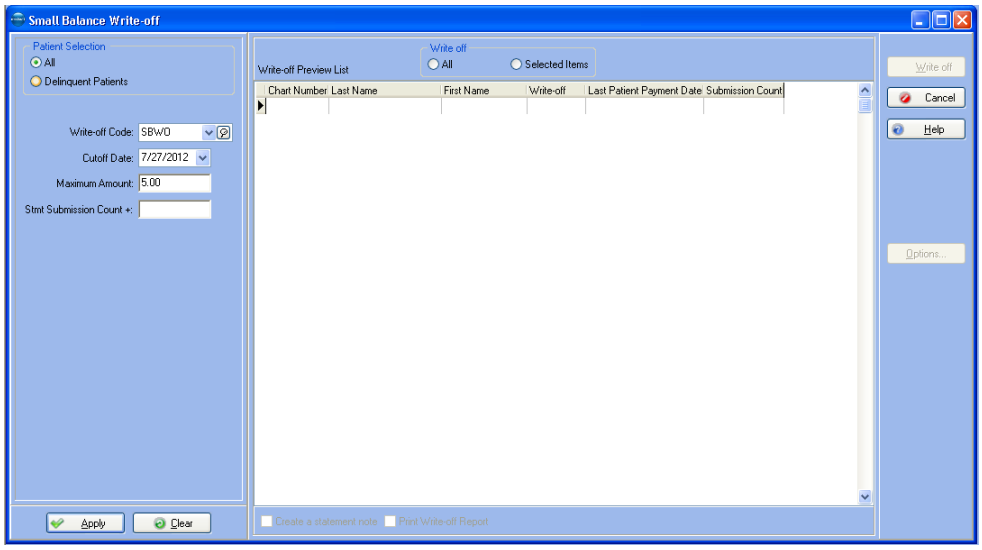

Figure 135. Small Balance Write-off screen

2. In the lefthand section of the screen, enter criteria for the type of remainder balances you want to write-off and click **Apply**. In the right hand section, a list of the patients who meet the criteria appears in the Write-off Preview List. The default is set to write off all records in the list. You can select individual records to write off by clicking on the record. Multiple records can be selected by pressing the CTRL key and clicking the record.
3. Click **Write off** to write off the selected remainder balances.

Use the Stmt Submission Count + field to define a maximum amount of times that you want to send a statement before writing off the balance. Once this number is met, the small balance is written off. Medisoft selects patients whose statements have been sent (submission count) more than the value entered in the field. Once this number is met, the small balance is written off. This field works in conjunction with the other fields on this screen. If a value is entered in this field, the balance is only written off if it meets the criteria for this field (completed the statements) and the other fields such as Maximum Amount field. For instance, if you enter 3 in this field and 10 in the Maximum Amount field, small balances would be written off after three statements are sent and if the balance is under $10.00.

When Medisoft writes off the remainder balances, it updates a number of other areas of the database. Write-off entries are created and applied to all patient responsible charges associated with the selected patient. Medisoft also updates the associated Collection List items, refreshing balances and marking zero balances as deleted. After a remainder balance write off, statements are changed to the status of Done and a note is added to the write-off entries.

Chapter 22 - Using Electronic Services

This chapter gives a brief overview of the electronic services available in Medisoft.

Electronic Claims Processing

Electronic claims send your insurance claims online either directly to the insurance carrier or to a clearinghouse, which then sends the claims to the insurance carrier. Medisoft currently ships with Revenue Management, an integrated component that installed when you installed Medisoft. To launch Revenue Management

- On the Activities menu, point to **Revenue Management**, and click **Revenue Management**.

Statement Processing

You can send statements electronically through BillFlash, the web-based company that is set up to process Medisoft electronic statements. Statements sent electronically through BillFlash get an instant response report that tells what information was sent. BillFlash will receive your statement data and then print and send statements to your patients. BillFlash can also receive payments from patients and you can download them to Medisoft and apply them to patient accounts.

Eligibility Verification

The Eligibility Verification feature lets you check a patient's insurance coverage online. Revenue Management conducts eligibility verification behind the scenes.

Eligibility Verification Setup

Before you can perform eligibility requests electronically, you must make sure certain information is in your practice records. Use the following table to help you verify your records are complete.

Field(s) to complete	screen or tab on which the field is located
Practice Tax ID	Practice Information screen, Practice IDs rules
Tax ID	Providers screen, Provider IDs tab (if this value is different from the Practice Tax ID above)

Field(s) to complete	screen or tab on which the field is located
Claims Payer ID	Insurance Carriers screen, EDI/Eligibility tab
Last Name, First Name, Date of Birth, Gender, Social Security Number	Patient/Guarantor screen, Name/ Address tab
Assigned Provider	Patient/Guarantor screen, Other Information tab
Insurance, Policy Holder, Relationship to Insured, Policy Number.	Case screen, Policy tabs
Assigned Provider	Case screen, Account tab

You must also apply security to your practice and create at least one user. For more information on Medisoft security, see “Security Setup Overview” on page 35.

Eligibility Verification Results

There are multiple places in Medisoft from which you can make eligibility verification requests: the Eligibility Verification Results screen, the Patient List screen, Office Hours, and the Task Scheduler screen. The type of eligibility inquiry you make, either real-time or scheduled, depends on the screen from which you are making the request.

Eligibility Verification Results

If you access this screen from the Activities menu, it will automatically show the last inquiry made for each patient. You can also set it to show all inquiries.

To make a real-time eligibility inquiry from the Eligibility Verification Results screen:

- Highlight the patient and click **Verify**.

Patients

To make a real-time eligibility inquiry for a specific patient:

1. Right-click the patient's case in the Patient List and select **Eligibility Verification**.

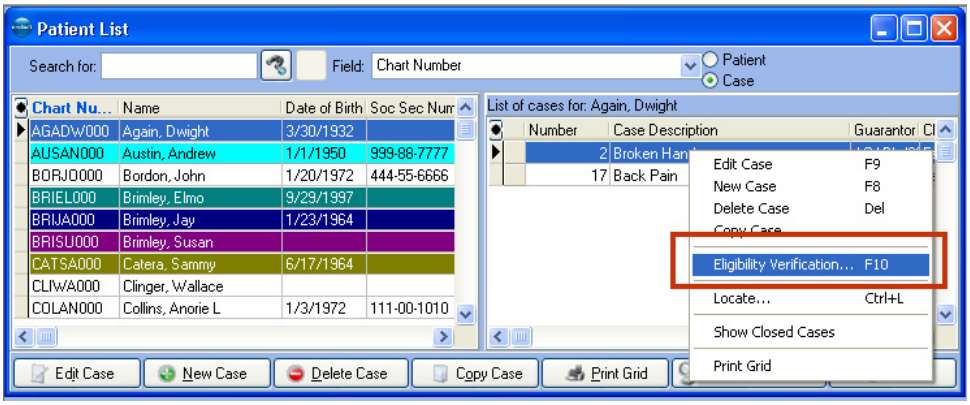

Figure 136. Patient List with Eligibility Verification highlighted

2. The Eligibility Verification Results screen appears.
3. Click **Verify** to make the inquiry.

TIP: Press F10 to launch the Eligibility Verification Results screen to verify a patient's eligibility.

Task Scheduler

You can use the Scheduled Tasks feature to schedule a daily time to send a batch of eligibility inquiries. To schedule a batch,

1. On the Activities menu, select **Eligibility Verification**.
2. Select **Schedule**. The Medisoft Task Scheduler screen appears.
3. Click **New**. The Select Type screen appears.
4. Select **Eligibility**.
5. Click **OK**. The Select Practice screen appears.
6. Select the practice and click **OK**. The New Eligibility Task screen appears.

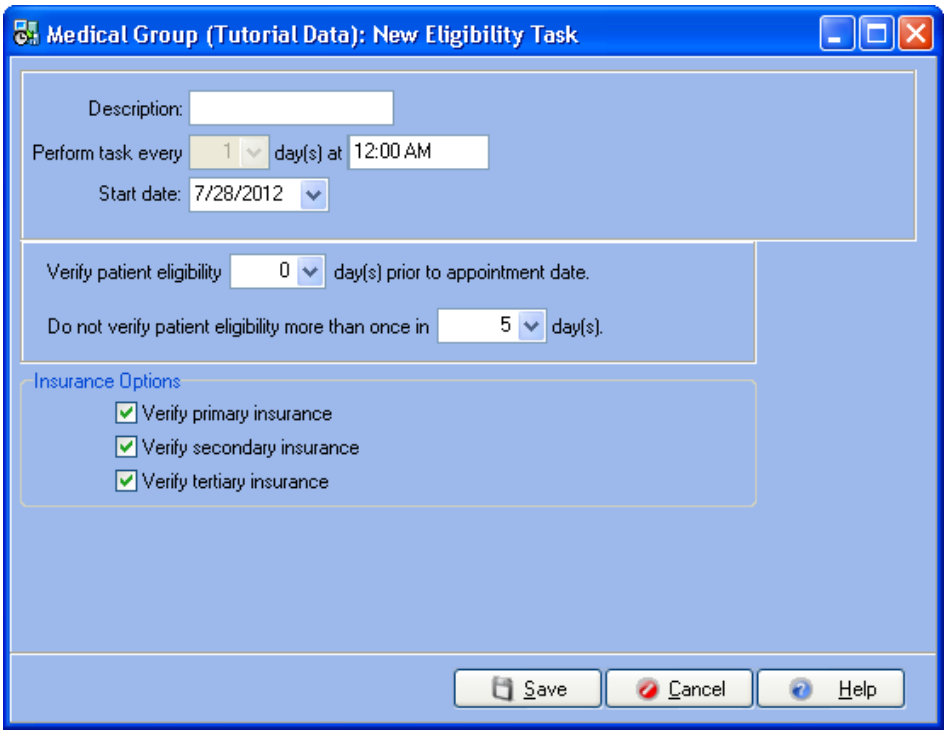

Figure 137. New Eligibility Task screen

7. Complete the options and click **Save**. The new task appears on the Medisoft Task Scheduler screen.

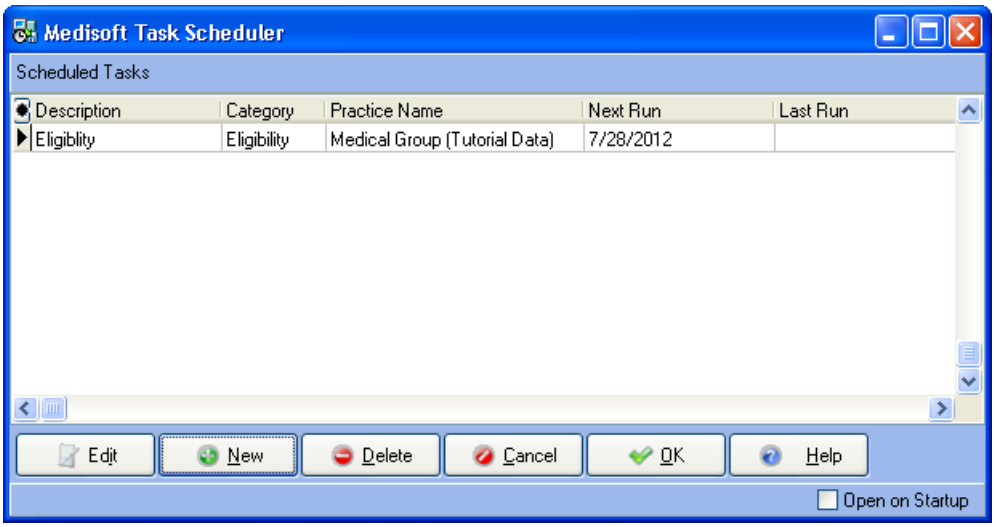

Figure 138. Medisoft Task Scheduler screen

The task will automatically make inquiries for patients scheduled in the appointment grid up to a week in advance.

Chapter 23 - Scheduling Appointments

In this chapter you will learn about Office Hours and some of the basic features available for creating and managing patient appointments.

Office Hours Overview

Office Hours is an appointment scheduling program that helps keep track of appointments for your practice. It is automatically installed with Medisoft.

Starting the Program

From the Windows Desktop

- Click the Office Hours Professional icon on your computer desktop.

From Within Medisoft

- On the Activities menu, click **Appointment Book**.

Office Hours Setup

There are several sections of the program that must be set up before you start scheduling.

1. First, set up provider records. If you are booking appointments for lab work or therapy, each of those technicians will have a provider number and schedule and so will each office member whose schedule will be included in the Office Hours program.
2. Set up your patient records.
3. Create your resource records. You can include all treatment apparatuses in this list, as well as consultation and treatment rooms, so that you do not double-book a room or equipment.
4. Set up program options, such as establishing appointment length, creating whatever views you need for viewing multiple columns at once, and deciding how much information you want displayed in your appointment blocks in the appointment grid.
5. Set up breaks and recurring breaks, to show lunch hour, set coffee-type breaks, seminars, and so on.
6. Set up security.

Using Office Hours

Entering a New Appointment

You can enter a new appointment on the Appointment Grid that opens when you start Office Hours. To create a new appointment

1. Select a provider in the provider field in the top right of the grid.

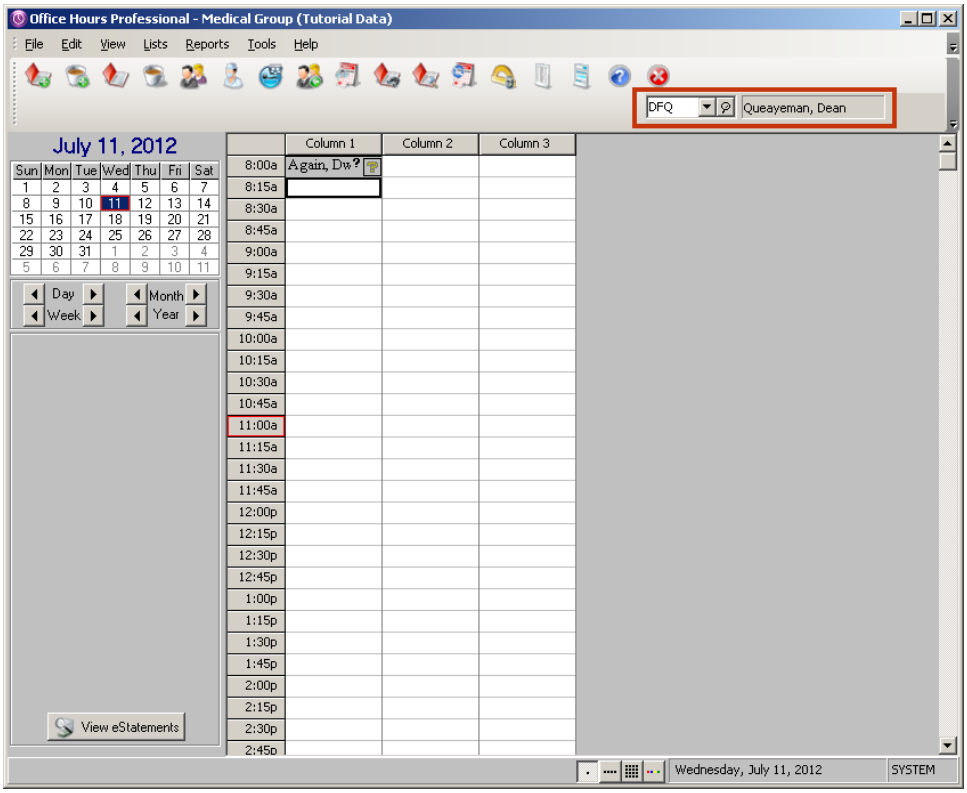

Figure 139. Appointment Grid

2. Double-click the timeslot for which you want to enter an appointment. The New Appointment Entry screen appears.

TIP: If you want to set up an appointment for someone who is not a patient and has no chart number, skip the Chart field and enter the person's name in the Name field. Enter all other necessary information. You can also print the appointment list showing blank appointments and manually write in appointments. Also, If a patient's case has an Authorized Number of Visits set on the Account tab of the Case screen, the program will warn you when the patient approaches the maximum number of authorized visits.

3. In the Chart field, type or select the patient's chart number.
4. Select a value for the Resource field.

5. Enter any notes about the appointment in the Note field. If you want to create a new line in the note, press CTRL + ENTER.
6. In the Case field the newest case entered for the patient appears. To change the case to which the appointment is tied, click the arrow to select the case.

Tip: You can right-click the field to create a new case, edit the selected case, or copy the selected case.

7. Select a value for the Reason field.
8. Enter the appointment length of time in the Length field. Enter the date in the Date field.
9. Enter the time in the Time field.
10. Select a button for the Status of the appointment. The default value is Unconfirmed.
11. If necessary, click Need Referral to indicate the patient does not have a referral for his or her visit.
12. If the patient must make a co-payment, click **Enter Copay.** This will open the Enter Copay screen on which you can enter the patient's co-payment. .
13. Click **Save**. The appointment appears on the Appointment Grid.

Find Open Time

You can use the Find Open Time feature to have the program search for the next available opening for an appointment. To do so

1. On the Edit menu, select **Find Open Time**. The Find Open Time screen appears.

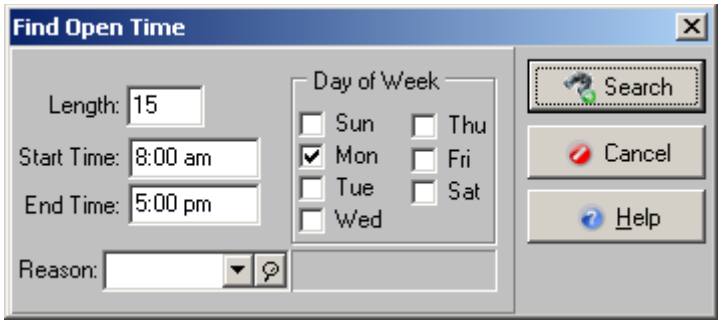

Figure 140. Find Open Time screen

2. Complete the fields and click **Search**. Office Hours shows you the next available time on the grid.

Go To Date

If you need to locate a date that is a given length of time in the future, use the Go To Date screen. To do so

1. From the Edit menu, click **Go to Date.** The Go to Date screen appears.

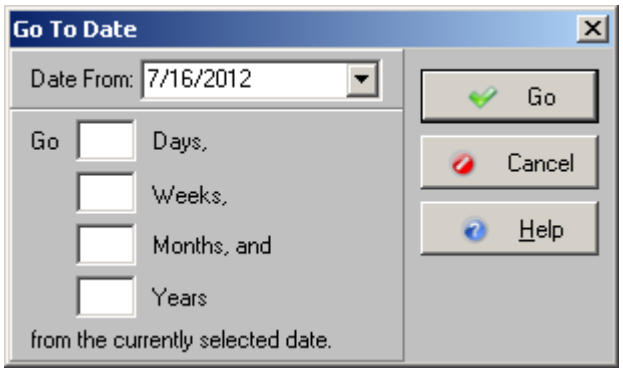

Figure 141. Go To Date screen

The date that defaults in the Date From field is the date that is currently selected in the calendar. If you want to change the date in the Date From field, replace it by either highlighting and typing in a new date, or click in the field or on the down arrow to the right of the field and the calendar opens.

2. Enter a number in one of the selection boxes to indicate how far in the future you need to make the appointment. For example, if you need an appointment in six months, type the number 6 in the Months field.
3. Click **Go**.

Wait List

The Wait List is available to track any unexpected patients who need to be seen that day. If no openings are available when patients call in, you can put them on the Wait List. If a time slot becomes available, you can use the Wait List to help you determine whom to call first for that opening.

Moving a Patient from the Wait List to an Open Appointment

1. On the View menu, click **Wait List**. The Wait List screen appears.
2. Use the Search/Sort by fields to search for a record. Select the field by which you want to search in Sort by and then enter the value for which you want to search in Search.
3. Select the **Provider.**
4. Choose a patient from the list and click and drag their name to an open time slot in the Appointment Grid.

Adding a Patient to the Wait List

To create a new entry for the Wait List:

1. On the View menu, click **Wait List**. The Wait List screen appears.
2. Click **New** in the Wait List**.** The New Wait List Appointment screen appears.
3. Select a patient in the Chart Number field. The patient's name and phone number are automatically entered in those fields when you tab past them.

NOTE: Entering a phone number here does not store that number in the patient's record. To include a phone number in the patient's permanent record, enter the phone number in the Patient/ Guarantor screen. You can move the cursor back to the Name field, and then press F9 to edit the patient record.

4. Complete the remaining fields on the New Wait List Appointment screen.
5. Click **Save**.

Editing an Appointment

To edit an appointment:

1. Double-click the appointment or right-click the appointment and click **Edit** from the drop-down menu. The Edit Appointment screen appears.
2. Make the changes you want.
3. Click **Save**.

Changing a Telephone Number or Cell Phone

If you update a patient's appointment with a new telephone number, you can also update all future appointments with the new phone number. When you enter the new phone number and click, the following screen appears:

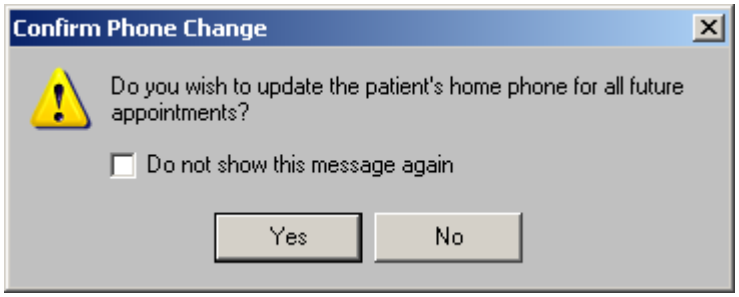

Figure 142. Confirm Phone Change screen

- If you click **Yes**, all future appointments are updated.
- If you click the **Do not show this message again** check box, the Confirm Phone Change screen will not appear in the future when you change other telephone numbers; the system will automatically update the phone number.
- If you click **No**, the patient's phone number for all future appointments will remain the old phone number.

Changing Other Information

If the field has an arrow key, you can click the arrow and then select from the drop-down list. If the field has a Search icon, you can click the icon and search for the corrected information.

Viewing Scheduled Appointments

You can view all the appointments scheduled for a patient.

1. On the Lists menu, click **Patient List**. The Patient List screen appears.
2. Highlight the patient whose appointments you want to view and click **Edit Patient**. The Patient/Guarantor screen appears.
3. Click **Appointments**. The Scheduled Appointments screen appears.

Figure 143. Scheduled Appointments screen

- Click **Show all appointments** to view all appointments for this patient.
- Click the **Edit** button to edit the selected appointment.
- Click the **New** button to create a new appointment.
- Click the **Delete** button to delete the selected appointment.
- Click the **Print** button to print the appointments in the grid.
- Click the **Close** button to exit the screen.

Viewing Future Appointments

You can see the future appointments for each patient. Future appointments can be scheduled for up to a year in advance. When you open the Future Appointments screen, however, only the next 60 days of appointments, based on the current system date, will appear. The future appointments that appear in this screen will change as the system date advances.

Using the Future Appointment List screen

1. Right-click the patient's appointment on the Appointment Grid and select **Future Appointments**. The Future Appointments List screen appears. It will show you appointments for this patient for the next 60 days.

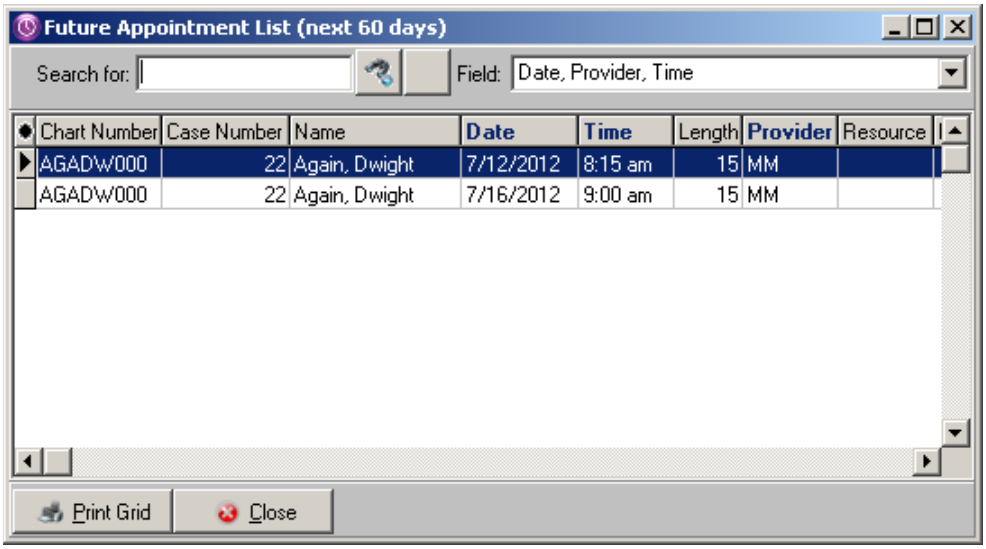

Figure 144. Future Appointment List (next 60 days screen

2. Click **Print Grid** to print the list or click **Close** to exit.

Using the Edit Appointment screen

Medisoft will also notify you if the patient has future appointments scheduled when you open the Edit Appointment screen.

1. From the Appointment grid, right-click an appointment and select **Edit**.
2. Press **Tab** to move the cursor to the Home Phone field.

3. If the patient has future appointments scheduled, you will see the notification on the screen.

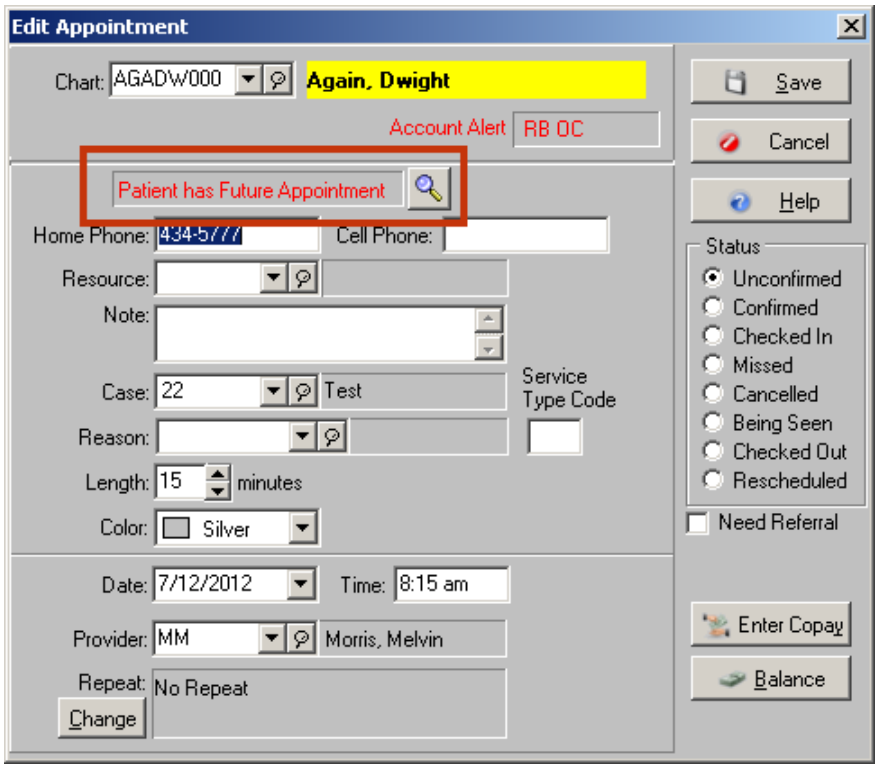

Figure 145. Edit Appointment screen with future appointment notification

4. Click the magnifying glass to open the Scheduled Appointments screen.

You can see all of the patient's appointments from this screen. You are not limited to the next 60 days.

Rescheduling an Appointment

You can reschedule an appointment by opening it and changing its status to Rescheduled. The Wait List will open, allowing you to find an open appointment time for the patient.

To reschedule an appointment:

1. On the Appointment grid, right-click the appointment and select **Reschedule**. The Wait List screen appears.

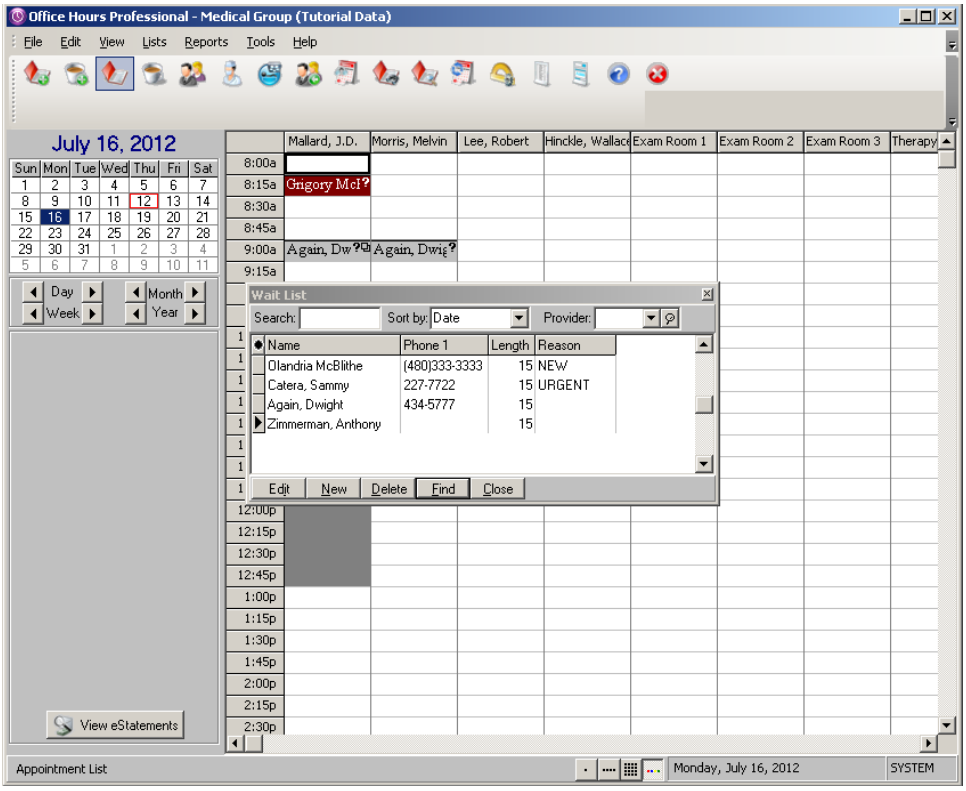

Figure 146. Appointment Grid with Wait List screen open

2. On the Wait List screen, click **Find**. The Find Open Time screen appears.
3. On the Find Open Time screen, select/modify criteria for selecting a new appointment.
4. Click **Search**. The Confirm screen appears.
5. On the Confirm screen, select one of these options

- Click **Yes** to set the appointment.
- Click **No** to reject the appointment.
- Click **Retry** for the next available appointment.

Moving/Deleting an Appointment

Moving an Appointment

To move an appointment, select one of the following methods:

Drag and Drop (changing to same day only):

1. Click the appointment and hold the mouse button down.
2. Move the cursor to the new appointment time.
3. Release the mouse button.

Using accelerator keys:

1. Highlight the appointment by clicking the grid cell.
2. Press ALT + X to cut the appointment.
3. Move to the new date on the Appointment Grid.
4. Click the new appointment time.
5. Press ALT + V to paste the appointment in the new location.

Using the Speed menu:

1. Highlight the appointment by clicking the grid cell.
2. Right-click the mouse and select **Cut**.
3. Move to the new date or new time.
4. Click the new appointment time.
5. Right-click the mouse and select **Paste**.

Using the Edit menu:

1. Highlight the appointment by clicking the grid cell.
2. On the Edit menu, select **Cut.**
3. Move to the new date.
4. Click the new appointment time.
5. On the Edit menu, select **Paste**.

Deleting an Appointment

To delete an appointment

1. Highlight the appointment on the grid by clicking it.
2. Right-click and select **Delete**.

NOTE: When you delete an appointment to which a numbered superbill is attached, the superbill is also deleted. The number may be released for reassignment.

Recalling Patients

The Patient Recall List screen displays all patients who have been set up for appointment recalls. The recall list provides staff a list of patients who need to be contacted for various reasons, for instance, contacting a patient regarding a follow-up visit or paying a bill.

This screen is for information purposes only and it does not integrate with any other part of Office Hours.

To open the Patient Recall List:

1. On the Lists menu, select **Patient Recall**. The Patient Recall List appears.

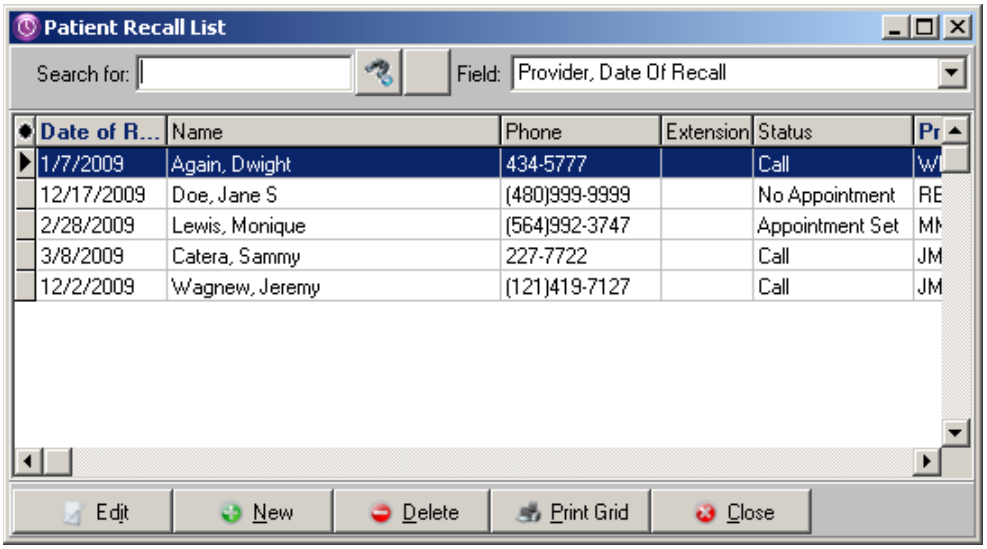

Figure 147. Patient Recall List screen

This screen is different from the other lists because you can search for a record by its date. When using the date as a search parameter, there are various date formats you can use. The following table explains the formats that are acceptable to use when searching.

2. From this screen, you can

- Click **New** to add a new entry.
- Click **Edit** to update an existing entry.
- Click **Delete** to remove an entry.
- Click **Print Grid** to print a list of patients on this list.

Setting Program Options

There are several options you can choose from. You can access Program Options from the Program Options option on the File menu.

Options tab

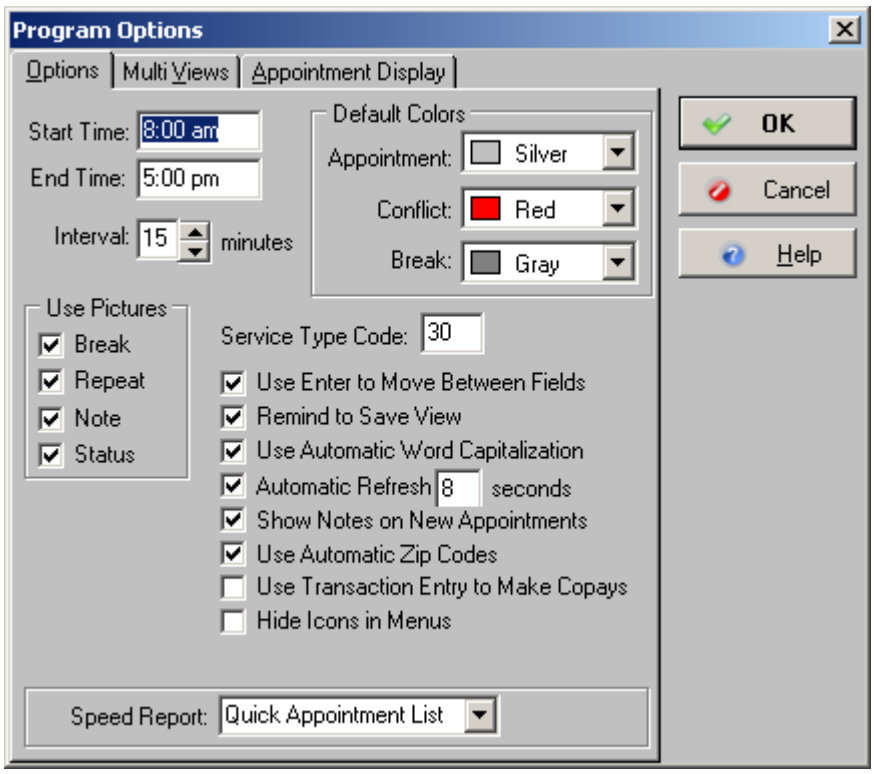

Figure 148. Program Options, Options tab

Set the starting and ending appointment times for the practice. Enter the Starting Time and Ending Time, breaking it down by hour and minutes. Standard appointment Intervals can be established by scrolling with the up and down arrows.

You can also set colors to distinguish appointments, breaks, and conflicts. Make decisions concerning all the other default settings in this tab.

Designate one of the reports in the Speed Report box and it will automatically print when you click the Print speed button.

You can now choose to use Deposit Entry or Transaction Entry when entering a copay. To use Transaction Entry rather than Deposit Entry, click the Use transaction Entry to Make Copays check box.

Multi Views tab

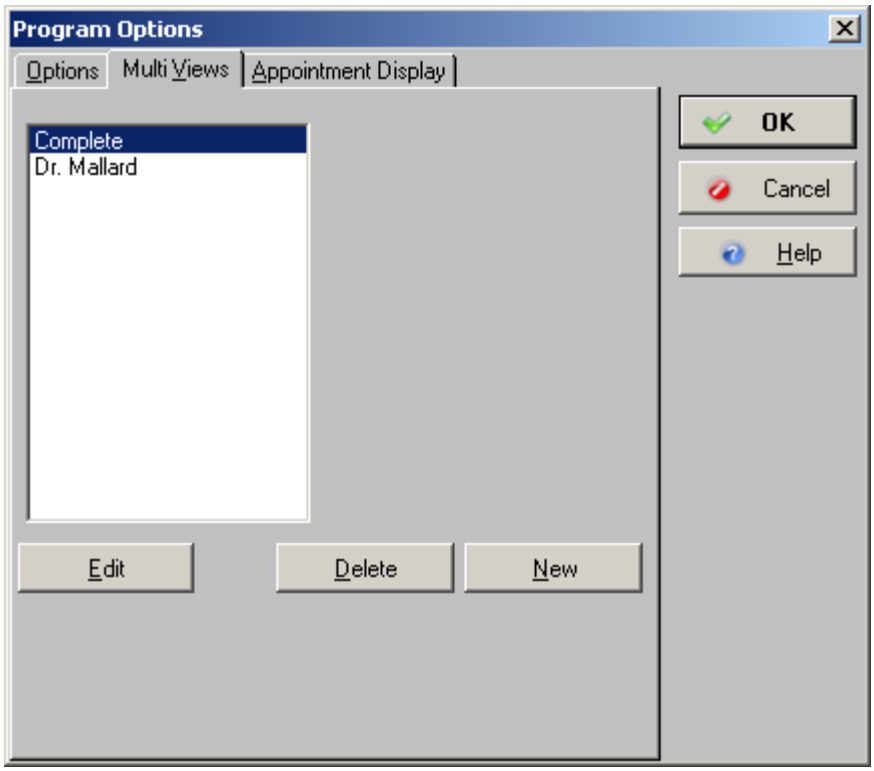

Figure 149. Program options, Multi Views tab

Office Hours provides one Multi View setup, which automatically includes all providers and all resources, each with its own column. You can create as many Multi Views as you need in the Multi Views tab.

The open data entry field lists all Multi Views that have been set up. This is where you can group providers and/or resources (rooms or facilities scheduled for appointments) in any combination desired, or modify or delete existing multiple view setups. Click New to set up a new Multi View (select a view and click Edit to make changes).

In the New View screen, assign a name for the new view. For the first column, indicate the type (Provider or Resource), the Code (provider number or resource code), then the width of the column (in pixels). Set up each column you want in the view and click Close when finished.

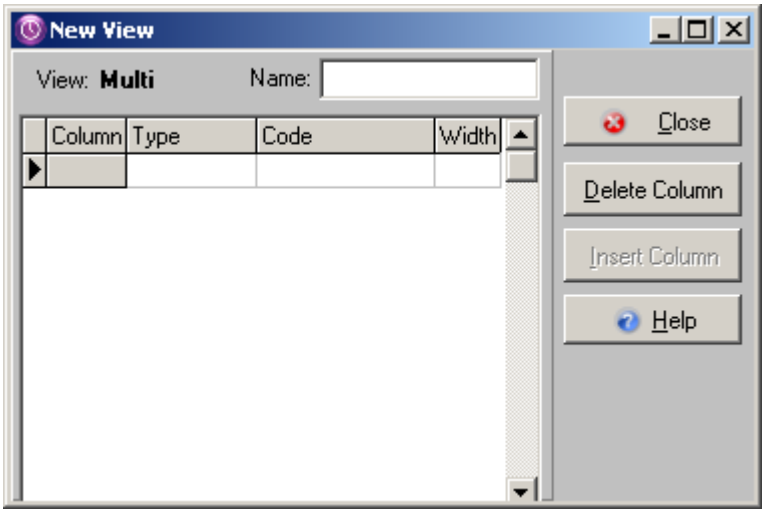

Figure 150. New View tab

If you want to add a column between columns that have already been created, place your cursor where you want the new column and click Insert.

These views can be also edited or reverted to default views through the View menu.

Appointment Display tab

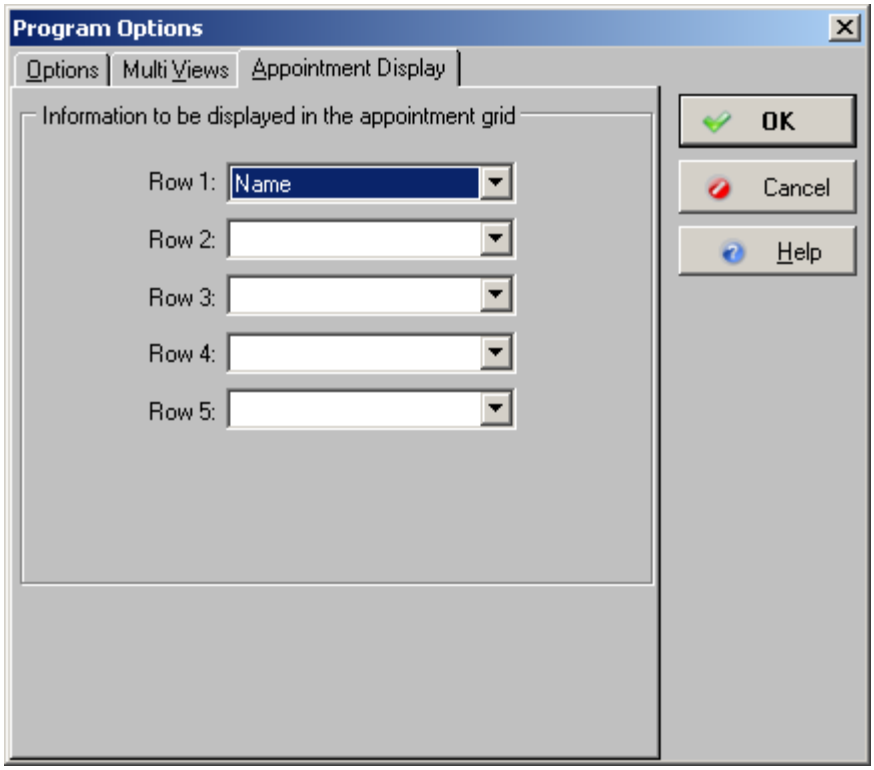

Figure 151. Appointment Display tab

In the Appointment Display tab, you can specify up to five rows of information to display in the grid for an appointment. Be aware that the length of the appointment determines how much data is actually displayed on the grid. An appointment must be at least 75 minutes long to display five rows of information.

Chapter 24 - Reports

In this chapter you will learn about reports in Medisoft.

Reports Overview

Medisoft offers flexible reporting options.You can run reports in Medisoft by selecting various reports from the Reports menu. In addition, you can launch the Medisoft Reports application (for Medisoft Advanced and Medisoft Network Professional only) and complete all reporting tasks there. The Medisoft Report application offers several key features not available when running reports from the Reports menu, including different reports and features to enhance productivity.

Report Procedures

Viewing a Report

You can view or preview a report before printing or exporting it. For example, you could preview a Patient Aging report before printing it to make sure that you have selected the most appropriate data criteria. After previewing, you can export or print the report.

To view a report:

1. On the Reports menu, select the report you want to view. The Print Report Where? screen appears.
2. Select **Preview the report on the screen**.
3. Click **Start**. Depending on the report selected, the Data Selection Questions screen or the Search screen opens.
4. Select ranges and then click **OK**. The report appears.

NOTE: For some reports that use a different format, such as statements, the controls in this screen are slightly different and include a Save Report to Disk option.

Printing a Report

To print a report:

1. On the Reports menu, select the report you want to print. The Print Report Where? screen appears.
2. Select **Print the report on the printer**.

3. Click **Start**. Depending on the report selected, the Data Selection Questions screen or the Search screen opens.
4. Select ranges and click **OK**. The Print screen appears.
5. Click **OK**.

Exporting a Report

You can export a report into another format. For example, you could export a Patient Aging report to a Microsoft Excel spreadsheet.

To export a report:

1. On the Reports menu, select the report you want to export. The Print Report Where? screen appears.
2. Select **Export the report to a file** and click **Start**. The Save As screen appears.
3. Select a file format for exporting and a destination.
4. Click **Save**. The Search screen or the Data Selections Questions screen appears (depends on the report or statement selected).
5. Select appropriate criteria and click **OK**. The report is exported.

Searching for a Specific Detail in a Report

Once you have generated a report, you can further refine the report and search for a more detailed data element. When using this feature, you essentially re-run a report using more specific data criteria.

To refine your data criteria and search for specific data:

1. View a report. See “Viewing a Report” on page 159.
2. Click **Search**. The Search screen appears.
3. Select specific data ranges.
4. Click **OK**. The report displays using the new search criteria.

Available Reports

Not only does Medisoft build an accounts receivable file and handle statements, insurance claims, and electronic billing, it also provides a variety of reports that can give you a better understanding of the day-to-day workings of your practice.

Among the reports generated within Medisoft are Day Sheets, Analysis Reports, Aging Reports, Productivity Reports (Network Professional), Activity Reports (Network Professional), Collection Reports (Advanced and Medisoft Network Professional), Audit Reports, Patient Ledger Report, Guarantor Quick Balance List (Network Professional only), and Standard Patient List Reports.

You can also print a title page that shows all the filters used in preparing the report.

Day Sheets

Day Sheets are available in three reports.

Report	Description
Patient	Lists each patient's name, showing all transactions and a summary of activities for the day.
Procedure	Breaks down by procedure code the activities of the day, summarizing patients treated for each procedure.
Payment	Shows the payments made on the requested day and the charges to which the payments are applied.

Analysis Reports

Report	Description
Billing/Payment Status Report (Advanced and Medisoft Network Professional)	Provides a thumbnail sketch of the current billing and payment status of each claim. The report shows what has been billed and not billed, what is delayed for some reason, if the carrier is not responsible or has refused the claim, or if the claim is paid in full. An asterisk (*) next to an amount indicates that the entity has paid all it is going to pay; and the balance, if any, should go to the next responsible payer.
Insurance Payment Comparison (Network Professional only)	Compares the payment records of all carriers in the practice.
Practice Analysis	Summarizes the activity of a specified period (for example, a month), listing each procedure performed, the number of times it was performed, and the total dollar amount generated by each procedure. It shows the average charge, includes any costs involved with that procedure, and calculates the net monetary effect on the practice's income.
Insurance Analysis (Advanced and Medisoft Network Professional)	Summarizes all claims filed by category (Primary, Secondary, and Tertiary). Claims totals are shown for charges and insurance payments in both dollar amount and percentage.
Referring Provider Report (Advanced and Medisoft Network Professional)	Shows which patients were referred by other practices and the percentage each referral contributes to the overall referred income of the practice, as of the date of that report. The report also includes the UPIN of the referring provider. By blanking out the Referring Provider range in the Data Selection Questions screen, a report can be generated showing what percentage of the entire practice has been referred.

Report	Description
Referral Source Report (Advanced and Medisoft Network Professional)	Assembles the patient list by source (other than provider) and shows how much revenue comes from each source, allowing the practice to identify those sources that send profitable referrals and/or limit those that are costly or nonproductive. This is another report for tracking the source of patients who come to the practice. For the report to work, however, all referral sources must be entered in the Address Book. A source can be an attorney, a hospital, friends, other patients, or anything else. Most new patient application forms include the inquiry "How did you hear about us?"
Facility Report (Network Professional only)	Tracks patients who are seen at different facilities. The Facility Report assembles the patient list by facility and shows how much revenue comes from each facility, helping you identify which generates the most money.
Unapplied Payment/Adjustment Report (Advanced and Medisoft Network Professional)	Shows any payment or adjustment that has an unapplied amount and where the transaction can be found.
Unapplied Deposit Report (Advanced and Medisoft Network Professional)	Shows all deposits that have an unapplied amount.
Co-Payment Report (Advanced and Medisoft Network Professional)	Shows all patients who have co-payment transactions. It shows the amount of the required co-payment, how much was applied, and what was left unapplied. If a patient does not have any co-payment transactions, he or she is not included in the report.
Outstanding Co-Payment Report (Advanced and Medisoft Network Professional)	Shows all patients who have outstanding co-payment transactions. The report shows the Co-payment amount expected, the actual amount paid, and the amount due. If a patient has no outstanding co-payment transactions, he or she is not included in the report.
Appointment Eligibility Analysis - Detail Report	Shows patients with appointments whose eligibility has been checked, based on criteria entered. It includes detail about the patients, their appointment date and time, the provider name, and reason code. It is an ARRA report designed for showing that the practice is verifying eligibility electronically.

Report	Description
Appointment Eligibility Analysis - Summary Report	Shows a summary of appointments whose eligibility has been checked, based on criteria entered. It is an ARRA report designed for showing that the practice is verifying eligibility electronically.
Electronic Claims Analysis - Detail Report	Shows the status of claims, providing a summary of total claims and those that have been filed electronically or by paper. It includes the percentage of claims filed electronically. In addition, it shows detail such as the billing date, insurance carrier, sequence, claim number, patient chart and name, and the status of the claim. It is an ARRA report designed for showing that the practice is sending claims electronically.
Electronic Claims Analysis - Summary Report	Shows the status of claims, providing a summary of total claims and those that have been filed electronically or by paper. It is an ARRA report designed for showing that the practice is sending claims electronically.

Aging Reports

Report	Description
Patient Aging	Shows patient aging. Default aging criteria is based upon the number of days between the creation of the transaction or claim and the date of the report you are generating. The columns break down the amounts due that are 30, 60, and 90+ days old. Aging is from actual date of the transaction, so it reflects the true age of the account. The aging criteria and columns can be altered in Program Options. This report includes all unapplied amounts in the totals. The Date filter has been removed as it would return invalid values.
Patient Remainder Aging (Advanced and Network Professional only)	Has the same format as the Patient Aging, but there is a key difference in how it works. A charge does not show up on the Patient Remainder Aging report until all insurance responsibility has been marked complete.
Patient Remainder Aging Detail (Advanced and Network Professional only)	Has the same criteria as Patient Remainder Aging Detail. However, it also lists each insurance company on the patient's account and the date the insurance payment was marked complete.
Insurance Aging and Summary	Track aging of claims filed with insurance carriers. The summary versions are similar but no patient information is included.

Production Reports

NOTE: This is a Network Professional only feature.

Report	Description
Production by Provider, Procedure, and Insurance and Summary	Gives incoming revenue information for each provider, procedure, or insurance carrier, respectively.

Activity Reports

NOTE: This is a Network Professional only feature.

Report	Description
Daily/Monthly Activity Report	Presents financial activity based on the date range selected. The report displays the total number and the total amounts of the charges, payments, and adjustments entered during a date range. The report also details the net effect of the financial information entered on the Accounts Receivable balance for the day/month.
Activity Summary by Provider/Insurance and Procedure	Breaks down financial activity by day or month. The summary reports summarize financial information entered for each provider/procedure or insurance carrier, respectively.

Collection Reports

NOTE: This is an Advanced and Medisoft Network Professional feature.

Report	Description
Patient Collection Report	Contains information based on statements marked Sent in the Statement Management screen, showing what has not been paid, statement date, and so on. Also, select this Patient Collection Report to generate the report with statement notes included.
Insurance Collection Reports	Shows the claim data, what amount is outstanding, and so on. These reports also offer variants that include claim notes.
Patient Collection Letters	Printed in preparation of collection letters. It contains information from the collection list and is used to help evaluate collections.
Collection Tracer Report	Reports how many collection letters have been sent and when. Each time collection letters are printed, Medisoft, by default, keeps track of each letter sent.

Audit Reports

Report	Description
Audit Generator	Creates a data audit report that contains only the information you want included in the report. This report is intended as a protection for the practice to keep track of changes made and by whom. Some PHI (personal health information) will be included in the Data Audit Report no matter what selections are made or excluded in the Program Options screen or the Audit Generator. **NOTE:** This report does not support printing a report title page even if the Print Report Title Page option was set in the Program Options screen.

Chapter 25 - Program Options

This chapter gives a brief overview of the different program options available in Medisoft.

General Tab

The General tab has options for backups, which are an essential part of maintaining computer-generated billing programs, and general default settings, such as which screen to open on startup, and several options to show or hide data.

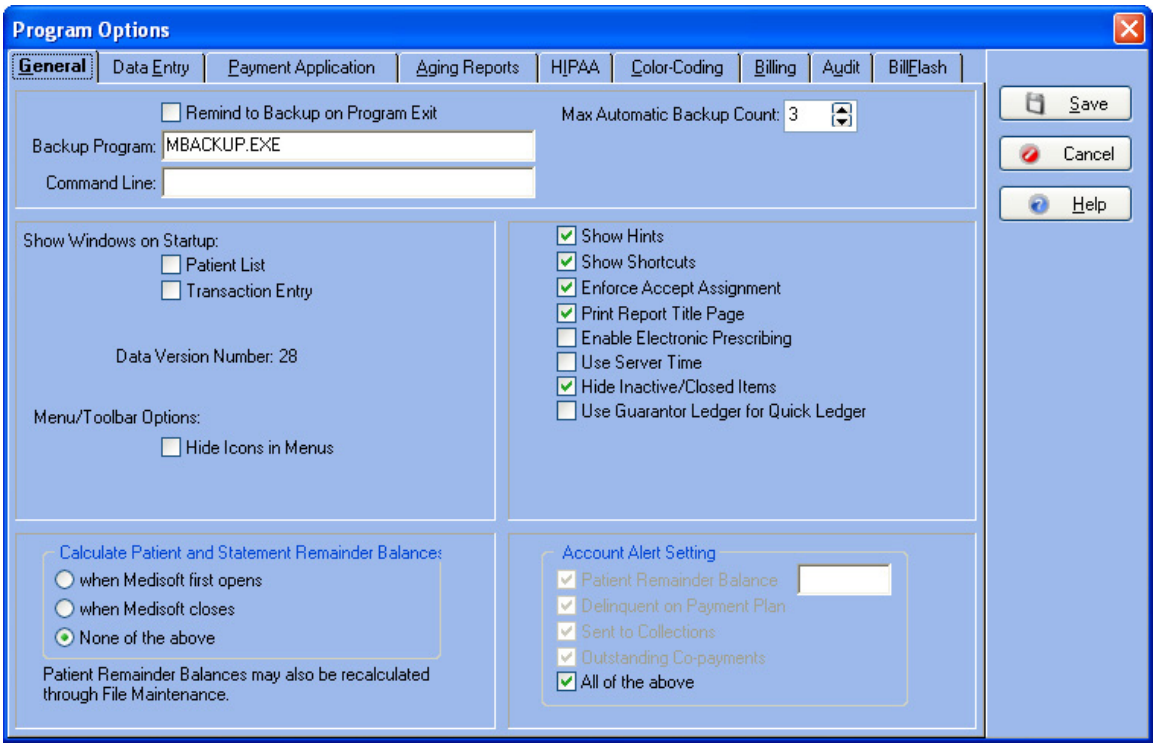

Figure 152. Program Options screen, General tab

Data Entry Tab

The Data Entry tab gives you many options for various sections of Medisoft.

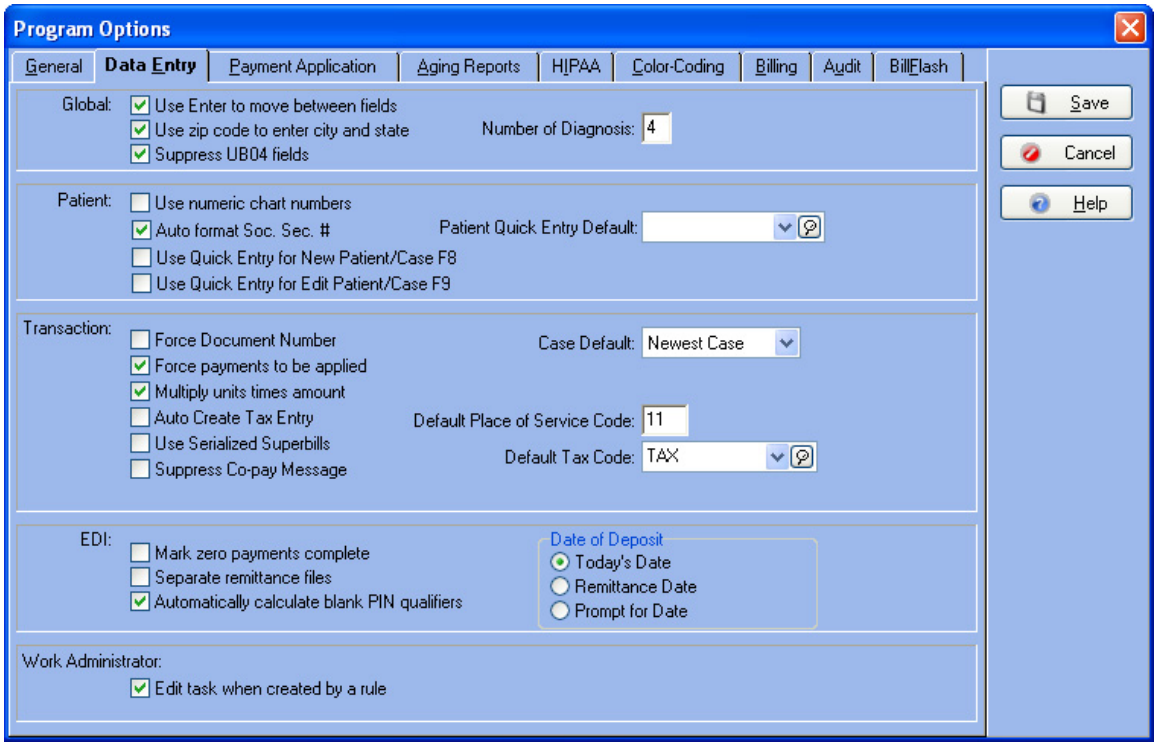

Figure 153. Program Options screen, Data Entry tab

In the Global section, you can indicate whether to use the ENTER key to move between fields, to force payments to be applied, and to multiply unit times amount. When the Suppress UB04 Fields check box is selected, UB-04 fields do not appear throughout Medisoft.

In the Patient section, you can choose to use numeric chart numbers (the default is to use an alphanumeric code) and/or have Medisoft automatically hyphenate Social Security numbers. The Patient Quick Entry Default list and the Use Quick Entry for New Patient/Case F8 and Use Quick Entry for Edit Patient/Case F9 check boxes provide setting options for the Patient Quick feature, which provides a custom method for creating records.

Payment Application Tab

NOTE: This is an Advanced and Medisoft Network Professional tab.

In the Payment Application tab, you can establish default settings that affect payments when you apply them to patient balances.

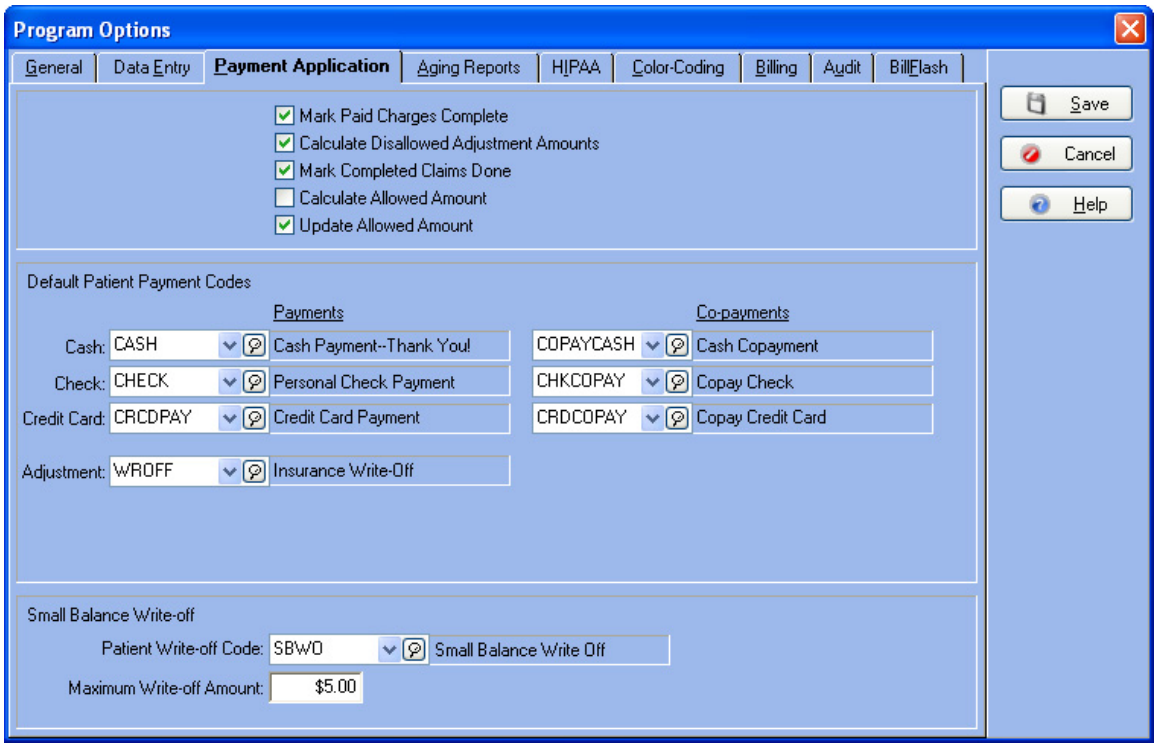

Figure 154. Program Options screen, Payment Application tab

If you choose to accept the default settings, any amount applied to a charge is automatically marked as paid by that particular payee, the allowed amount is automatically calculated, and the difference between the calculated allowed amount and the practice charge is offset in the Adjustment column. In addition, any claim that has received payment from all responsible payers is automatically marked “Done.”

In the lower half of the screen, select default billing codes to be applied when using this feature.

Aging Reports Tab

The Aging Reports tab lets you alter the starting date for patient aging reports and to redefine aging columns for both patient and insurance aging reports.

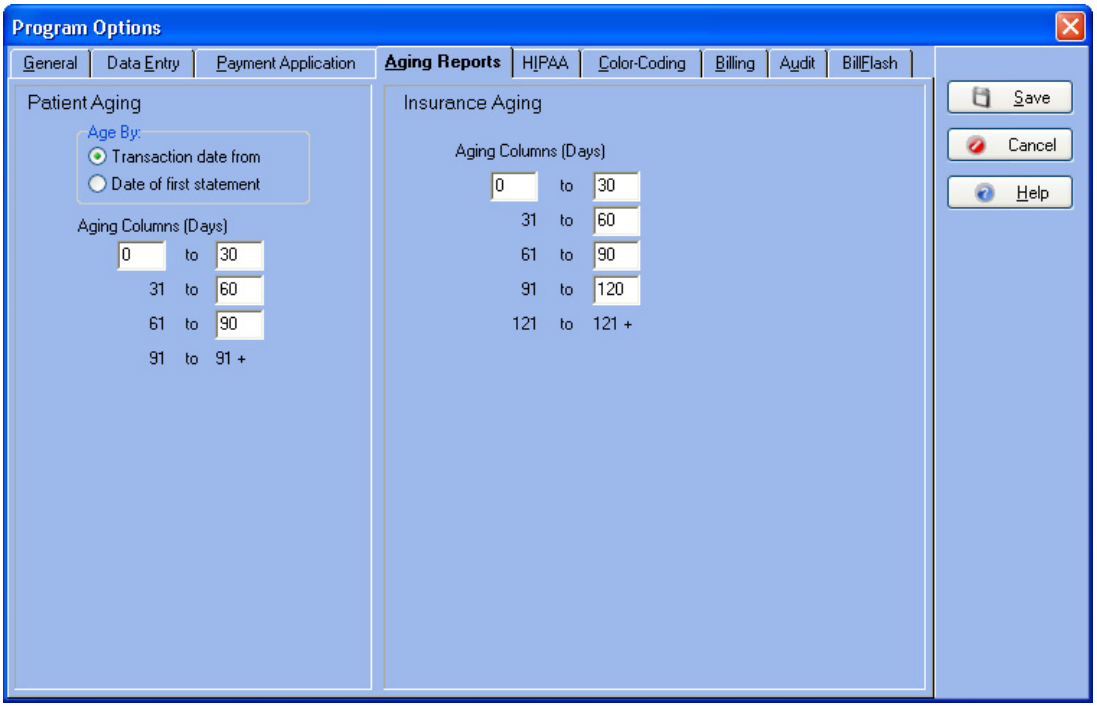

Figure 155. Program Options screen, Aging Reports tab

HIPAA Tab

The HIPAA tab offers features designed to help protect patient information from unauthorized access.

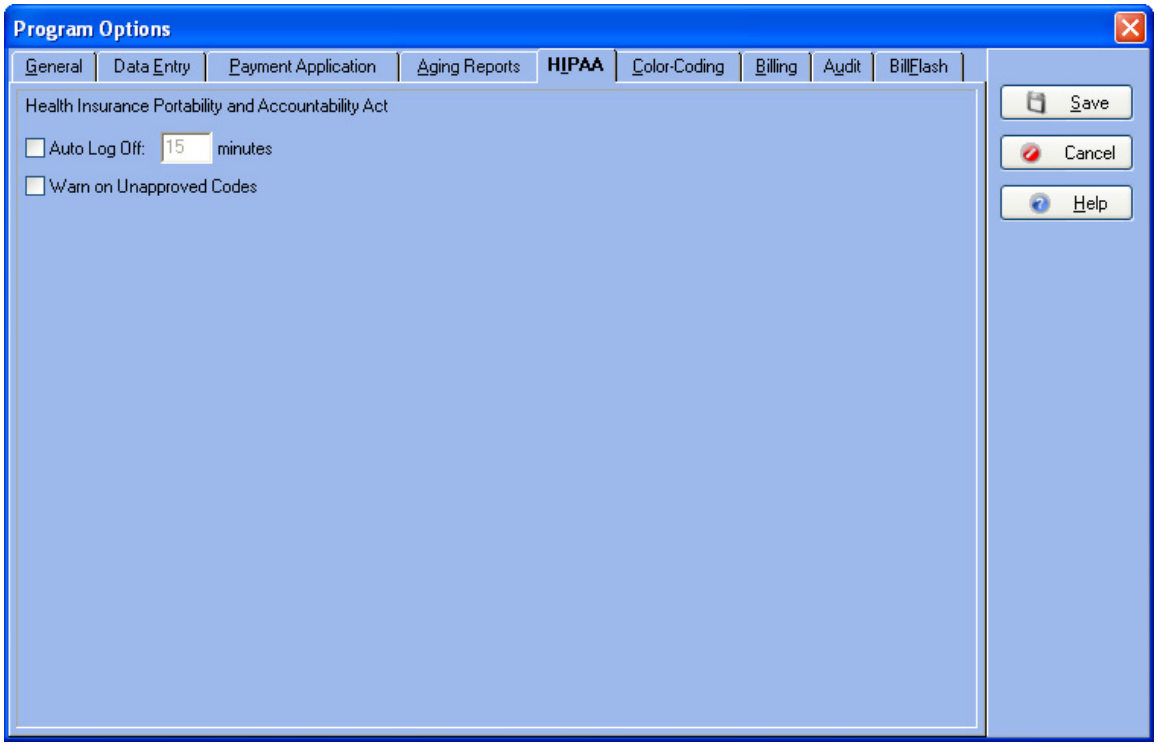

Figure 156. Program Options screen, HIPAA tab

The Auto Log Off check box is designed to protect your data files from unauthorized tampering. Select the check box and then enter a number of minutes (up to 59) in the field. With Auto Log Off activated, any time Medisoft remains unused for the amount of time designated, it locks the practice and requires re-entry of a password to access Medisoft again.

If you select this check box and have not used the Security Setup feature in Medisoft, a message pops up telling you that security has to be set up before the backup will function. For more information on security, see “Security Setup Overview” on page 35.

When the Warn on Unapproved Codes check box is selected, Medisoft alerts you if a code entered or selected is non-HIPAA compliant. This warning pops up every time you save transactions and Medisoft finds a code that has not been marked HIPAA compliant.

Color-Coding Tab

NOTE: This is an Advanced and Medisoft Network Professional tab.

Transactions

If you want to use color coding for transactions in Transaction Entry and Quick Ledger, select the Use Color Coding check box.

Select colors for each of six types of transactions: unsaved, no payment, partially paid, overpaid charge, unapplied payment, and overapplied payment. These colors appear in both screens, letting you know at a glance the status of the transaction.

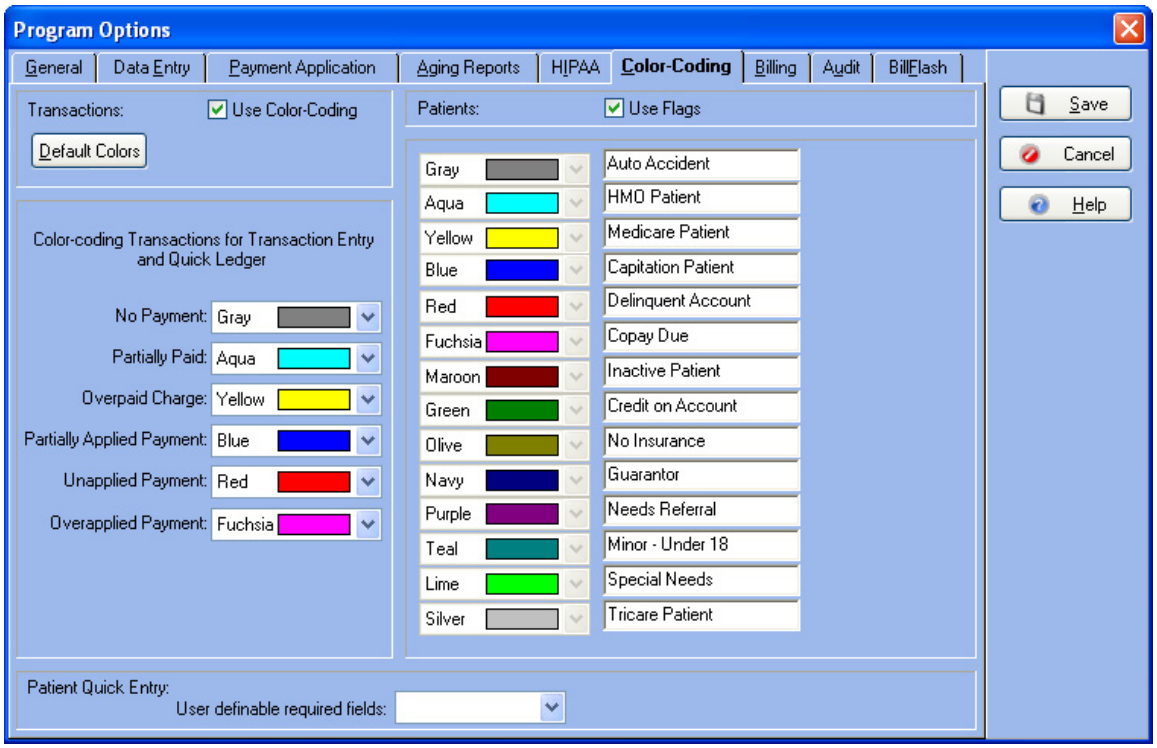

Figure 157. Program Options screen, Color Coding tab

Patients

This feature, called patient flagging, lets you color code patient records to alert you to various situations when viewing records.

The patient flag colors in the Program Options screen are fixed and cannot be edited. In the box to the right of a color box, assign your own description to that flag color. To activate the edit boxes, select Use Flags.

Patient flags are connected to patient records in the Other Information tab of the Patient/Guarantor screen as you edit or set up a new patient record.

Billing Tab

NOTE: This is an Advanced and Medisoft Network Professional feature.

Statements

Options in the Statements section deal with billing cycles. If you want to use billing cycles when sending statements, select the Use Cycle Billing checkbox. If you choose to use cycle billing, be sure to enter a cycle billing days interval (for example., every 30 days). For more information on billing cycles, see "Billing Cycles" on page 119. Statements sent through BillFlash are also affected by the billing cycle.

The Add Copays to Remainder Statements is used to add missed copays (when patients do not immediately pay their copay), to the patient's Copay Remainder statement.

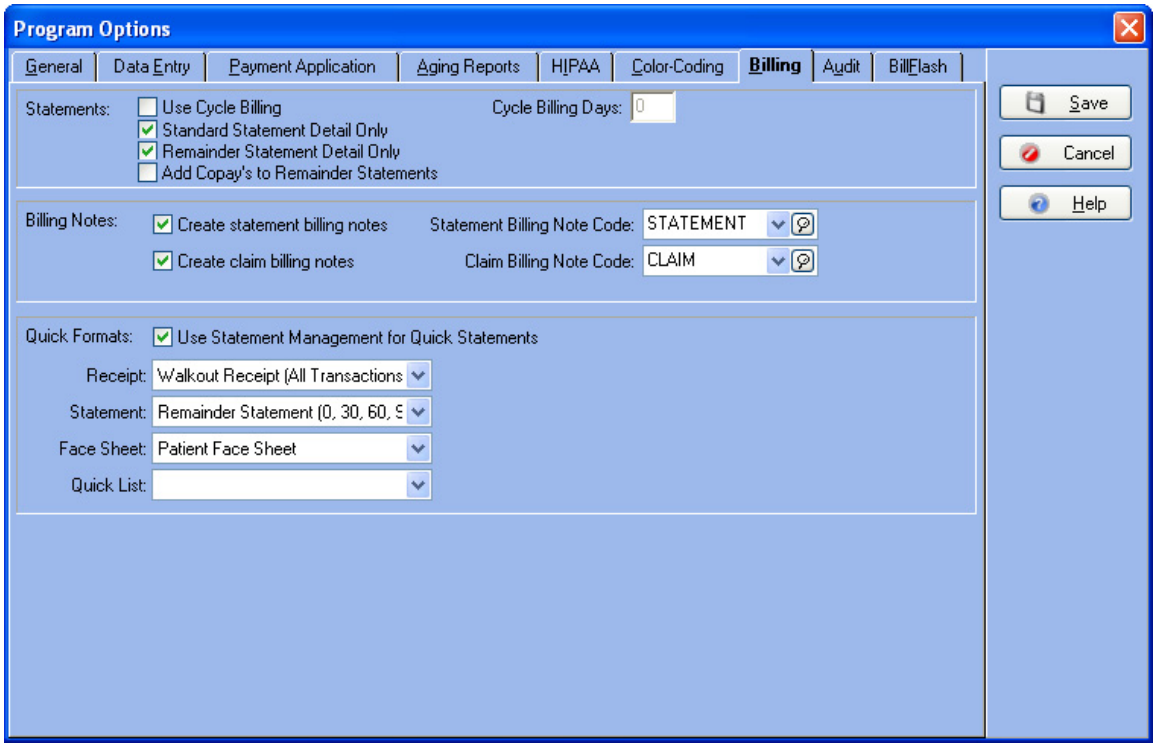

Figure 158. Program Options screen, Billing tab

Billing Notes

When you select Create statement billing notes, Medisoft adds a note to statements when printed. Be sure to select a default note in the Statement Billing Note Code field.

When you select Create claim billing notes, Medisoft adds a Comment transaction line in both Transaction Entry and Quick Ledger whenever a claim is billed. The note includes the carrier name, date billed, claim number, and the name of the provider associated with the claim. Be sure to select a default Claim Billing Note Code.

Audit Tab

The Audit tab lists all tables available in the database. The tables you choose here become available in the Audit Generator when preparing the Data Audit Report.

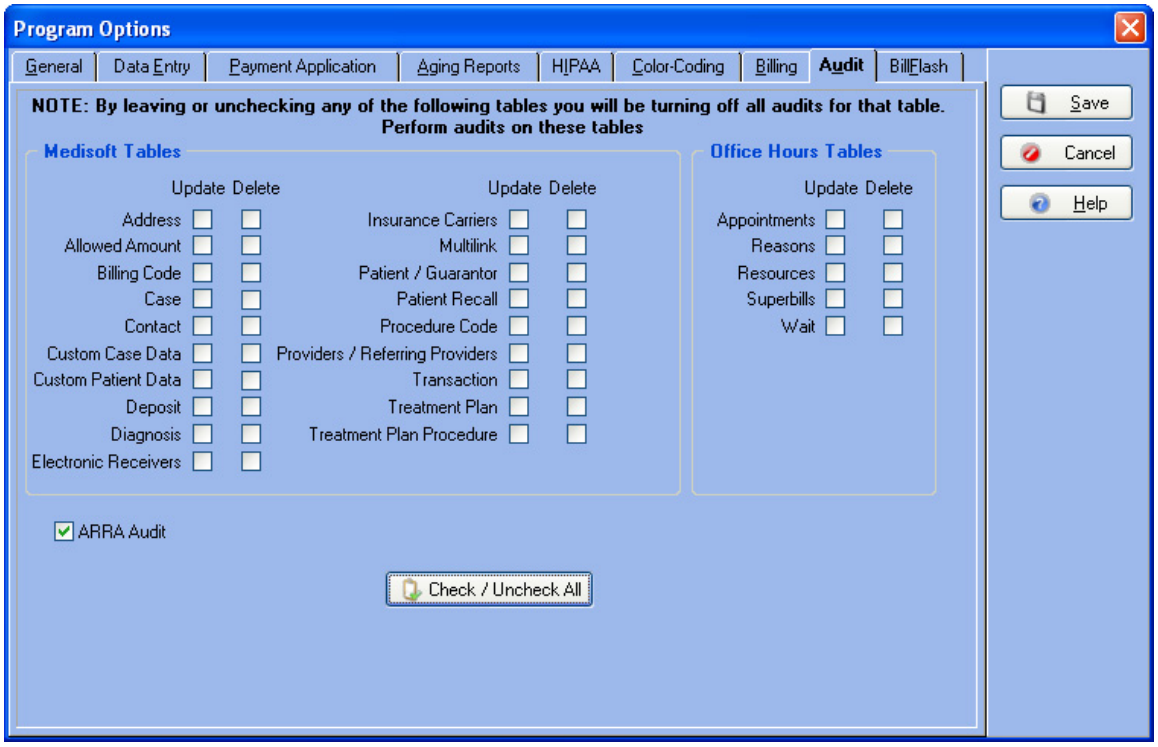

Figure 159. Program Options screen, Audit tab

BillFlash Tab

The BillFlash tab allows you to control some of the information that appears on the statements you send electronically via BillFlash, the web based company that is set up to process electronic statements in Medisoft.

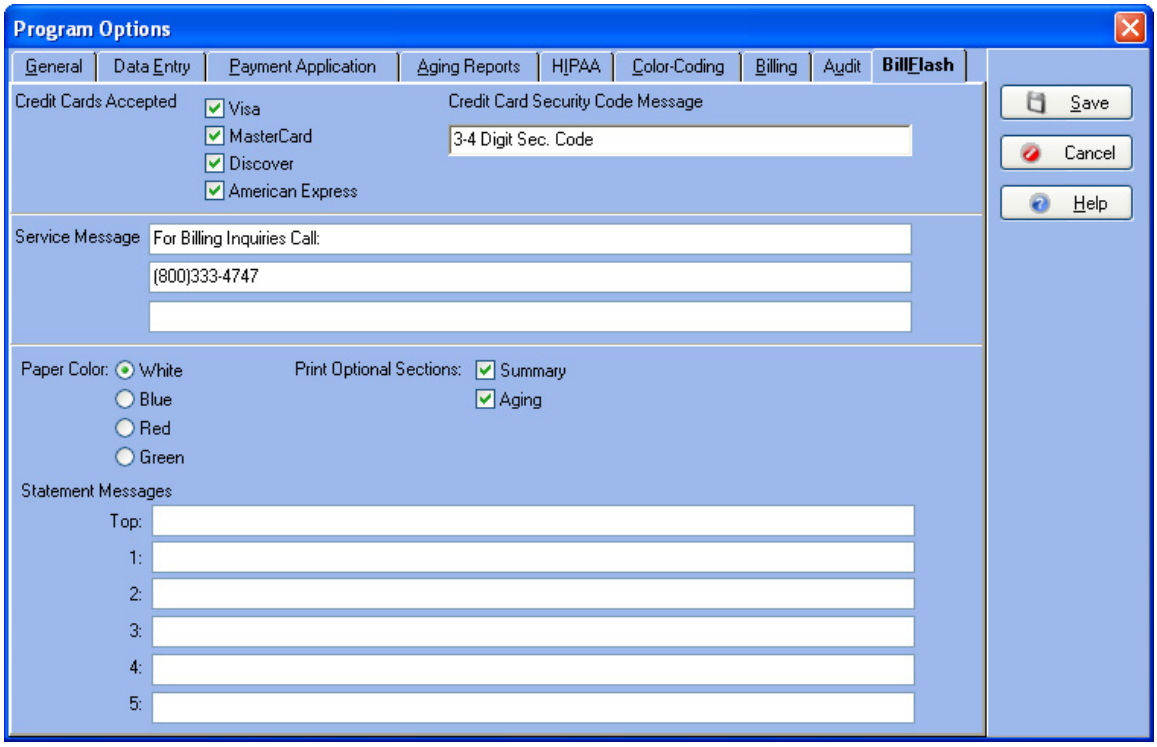

Figure 160. Program Options screen, BillFlash tab

Chapter 26 - Backup and Restore Data

In this chapter you will learn how to back up and restore data using both the regular and hot backup/restore features.

Backing Up Your Data

Making regular backups is essential to good maintenance of your data.

TIP: **Best Practice**--consider backing up data files every day so you can restore lost data to the most recent date before the files were damaged or corrupted. If you are working with multiple practices, each practice will have its own set of backup files. Doing your backups within the Medisoft program is a dependable method.

To make a backup:

1. On the File menu, select **Backup** and then **Backup Data**.

2. Click **OK** on the warning message. The Medisoft Backup screen appears.

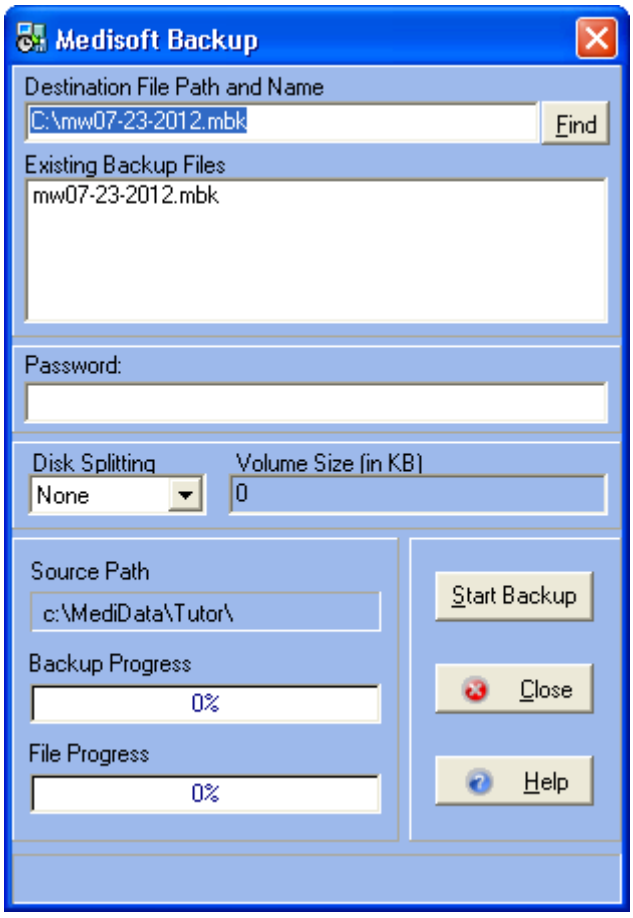

Figure 161. Medisoft Backup screen

3. Complete the fields on the screen.
4. Click **Start Backup**.
5. Click **OK** on the message that the backup is complete.

Restoring Your Data

You will very seldom have to restore a backup. it is only necessary if the data becomes corrupted or you have to print reports that are no longer accessible because of the addition of new data.

McKesson highly recommends that you create a new backup of your current data BEFORE you restore your backup. You may need this backup to restore your files to their current state.

To restore a backup:

1. On the File menu, select **Restore**.

2. Select **Restore Backup**.
3. Click **OK** on the warning message. The Medisoft Restore screen appears.

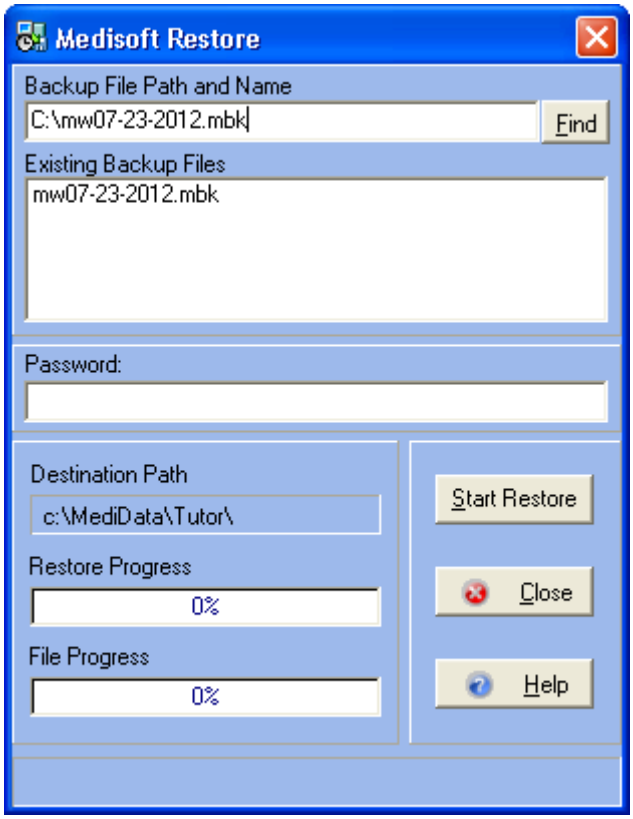

Figure 162. Medisoft Restore screen

4. Select a backup on the list of existing backups or click **Find** to find a different backup.
5. Click **Start Restore**. A confirmation screen appears.
6. Click **OK**.The backup is restored.
7. Click **OK**.
8. Click **Close** on the Medisoft Restore screen.

Making a Hot Backup

This feature is for Medisoft Network Professional only.

Hot Backup allows you to make a backup of your data while other users are still working in the practice. Hot Backup will ensure that processes are completed before creating the backup. Once the backup is complete, you will be logged out of Medisoft and must log back in to resume work.

To make a hot backup:

1. On the File menu, select **Backup** and then **Hot Backup**. The Medisoft Hot Backup screen appears.

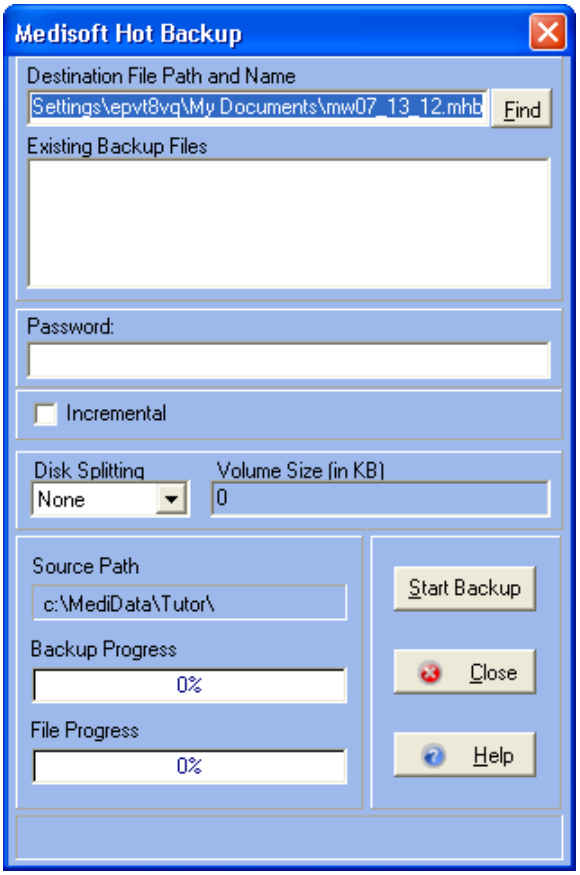

Figure 163. Medisoft Hot Backup screen

2. Complete the fields on the screen.
3. Click **Start Backup**.
4. Click **OK** on the message that the backup is complete.

Restoring Your Hot Backup

You will very seldom have to restore a hot backup. it is only necessary if the data becomes corrupted or you have to print reports that are no longer accessible because of the addition of new data.

McKesson highly recommends that you create a new backup of your current data BEFORE you restore your backup. You may need this backup to restore your files to their current state.

To restore a hot backup:

1. On the File menu, click **Restore**.
2. Click **Hot Restore**.
3. Click **OK** on the warning message. The Medisoft Hot Restore screen appears.

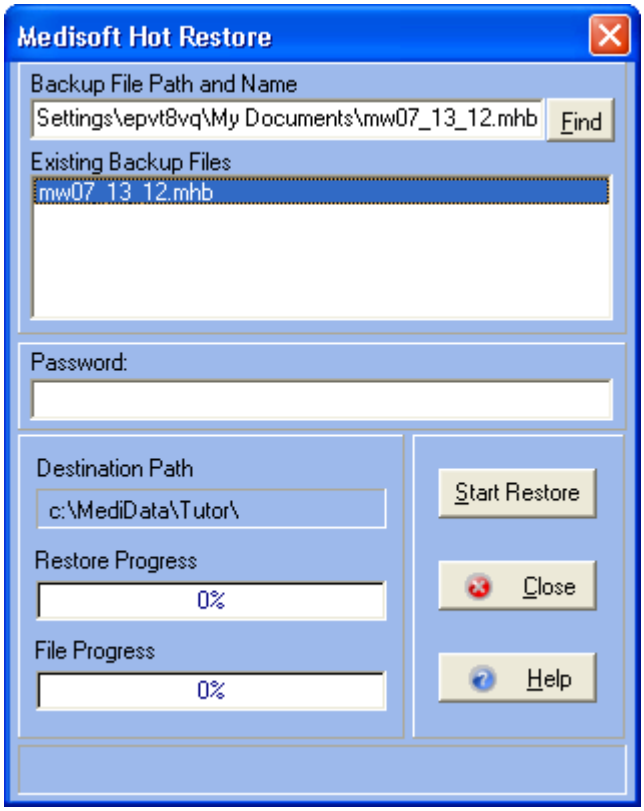

Figure 164. Medisoft Hot Restore screen

4. Select a backup on the list of existing backups or click **Find** to find a different backup.
5. Click **Start Restore**. A confirmation screen appears.
6. Click **OK**.The backup is restored.
7. Log back into Medisoft.

Glossary

This section defines terms used in the User Guide.

Care Plan Oversight Number

This is the number physicians have if they have supervision of Medicare patients under the care of hospices or home health agencies that require complex or multidisciplinary care.

CLIA Number

This is Clinical Laboratory Improvement Amendment Number. This number is required for all laboratory claims.

Communications Manager

This is a separate application installed with Medisoft that enables Medisoft to communicate with an Electronic Medical Records software, such as Practice Partner.

EDI Receivers

These are the organizations to which you send claims or eligibility requests.

EOB

An EOB is one or more ready-to-mail forms containing claim-specific information. Each form lists the carrier's payments, allowances, and insurance filing activity. EOBs are used mainly to inform secondary carriers of the payments and disallowances posted to a claim by the claim's primary carrier.

Insurance Class

Insurance classes enable you to categorize insurance carriers into groups.

Legacy identifier

This refers to a provider number or identification number other than NPI, such as a BCBS provider number, Unique Provider Identification Number (UPIN), Medicare number or Medicaid number.

Level One user

This is a user with the highest access level in Medisoft, often an administrator.

List screen

These are screens that show lists of information, such as providers, insurance carriers, and so on. From these screens you can select an item to edit or create a new item for the list.

Mammography Certificate Number

The Mammography Certification Number is assigned to a provider certified to perform a mammography and is required on all mammography claims.

National Provider ID

This refers to a unique number for a physician or practice that identifies them.

Open Item Accounting

A type of accounting where charges and payments for patients remain on the books and are not lumped together at the end of a fiscal period or year.

Provider Class

The provider class is a way of categorizing providers into groups.

Quick Ledger

The Quick Ledger is a feature of Medisoft that gives a quick reference for transaction and other information in the patient's account.

Revenue Management

This is the application that is bundled with Medisoft that enables a user to transmit claims and eligibility payments electronically.

Rules

Rules are logic patterns set up in Medisoft to ensure that claims are processed correctly for providers and practices based on requirements set by the government and insurance carriers.

Superbill

The superbill is designed to be a physician's worksheet. The superbill displays a list of what procedures can be performed by the provider and the diagnoses related to it displayed in a list format.

Taxonomy Number

This is a number that specifies the type of practice the physician is in, for example, family practice or emergency medicine

UB-04

This is a form used by institutions to file claims to insurance carriers.

Unique Physician Identification Number (UPIN)

The Unique Physician Identification Number (UPIN) is a number assigned to physicians and others who are enrolled in the Medicare Program.

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